Ontario

Secretariat for Social Development

The Elderly in Ontario: An Agenda for the '80s

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Task Force on Aging Report Contents

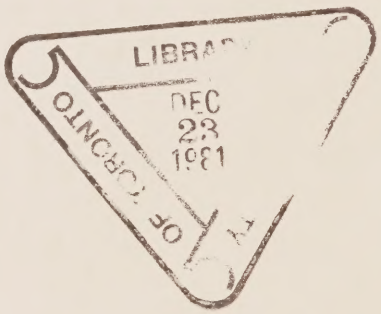
Terms of Reference

1. To review all recent reports and recommendations of advisory and special purpose interest groups relative to policies for the aged for the purpose of identifying existing program suggestions which are worthy of further study for potential implementation.

2. To examine all existing programs for the aged and to develop original and creative actionable policy proposals that respond to needs not being appropriately addressed at the present time, suitable for implementation in the short and medium term.

3. To assess the impact of various demographic trends already under analysis in the Secretariat for Social Development in order to indicate possible long-term policy initiatives for the 65+ client group.

4. To consult with and obtain information from other ministries as required.



Letter of Transmittal

TASK FORCE
ON AGING

Honourable Margaret Birch
Provincial Secretary for
Social Development
1st Floor, Whitney Block
Queen's Park
Toronto, Ontario
M7A 1A2

Dear Mrs. Birch:

We the members of the Task force on Aging take pleasure in presenting our final report.

The report reviews current policies and programs of the Government of Ontario which affect the elderly of today and presents a set of recommendations to serve as an agenda for government's consideration in preparing for tomorrow.

During our study, the Task Force was impressed with the extent of commitment already made by the Province to the elderly and by the general public acceptance of the main features of current policies.

The Task Force wishes to record our appreciation and thanks to the many ministry representatives who contributed substantially to the report by compiling data and cross-checking figures.

We wish also to record our special thanks to David Kennedy who served so ably as Executive Secretary.

Yours sincerely,

B. J. Harper

Bryce Harper
Chairman

David Bogart
Member

Mary Louise Gaby
Member

Glen Peppiatt
Member

John Nywening
Member

Acknowledgements

This report could not have been completed without the support of many talented professionals within the Provincial Government who contributed their expertise to the work of the Task Force on Aging. The extent of the support received by the task force reflects a high professional commitment to the needs of the elderly.

It would be difficult to list all those who contributed to the task force's deliberations. We would, however, like to mention the special contributions of the following: Alan Borovsky, Lawrence Crawford, Martha Goodings, John Stapleton, Tim Young (Ministry of Community and Social Services); Wilson McCue (Ministry of Culture and Recreation); Dorothy McPhedran (Ministry of Education); Yale Drazin, Stephen Newroth, Penny Palmer (Ministry of Health); Fergal Nolan (Ministry of Northern Affairs); Nick Kristoffy (Ministry of Municipal Affairs and Housing); Bernice Levitt (Ministry of Treasury and Economics).

The task force also consulted with the Advisory Council on Senior Citizens and found their reports and advice useful in the preparation of this document. The Advisory Council on Senior Citizens provided a useful senior's viewpoint for program review.

The task force received valuable and skilled secretarial and editorial assistance. We would specially like to note the assistance of Judy Morimoto, senior secretary to the task force, and the editorial and production assistance of Christine Purden, Lee Palmer MacLeod, and Jim Bard.

David Kennedy
Executive Secretary

The Elderly and the Government

Introduction

Ontario residents are, in general, producing fewer children and living longer than their parents did. These two demographic trends, plus changes in the number of persons moving to and from the province, are affecting the fundamental makeup of our society. In the years to come the effects of such population changes will be profound. They will touch all our lives.

Fact–In Ontario in 1980, 840,000 persons are 65 and older. This is 10 percent of our total population.

Projection–By the year 2001, the elderly will constitute 14 percent of our population. By the year 2021, the impact of the post-World War II birth rate explosion or Baby Boom will have been felt. The elderly segment of Ontario's population will have more than doubled to 20 percent or 2,046,000 persons.

Fact–Ontario Government expenditures in 1980 for all programs for the elderly totaled $2,135 million. This is an increase of close to 600 percent in 10 years, a statistic that reflects the number of services and programs launched during that decade. The elderly population increased by 34 percent during the same period.

Projection–By 2001, this expenditure will increase by almost 80 percent if current patterns of use do not change. In 1980 dollars, the cost would be $3,830 million.

Fact–The majority of elderly today have retired from the work force. They rely on income from contributory pensions, personal savings, investments and income supplements from government. Particularly after age 75, increasing numbers of elderly experience declining health, which leads to increased use of costly health services. In some cases they need help with daily living, assistance that comes from family, friends, volunteer groups and government. This growing segment of the population uses health and social service resources at a high rate.

Projection–It is clear that in the long term, the Province will face a challenge in maintaining the benefits now provided. What is not clear is the full impact of our aging society on programs and benefit levels. There are two key reasons.

1. Many of the existing programs for the elderly are new. Therefore statistics on which to base projections are imprecise.

2. There are many unknowns about the 'new' elderly who will be retiring during the years under study. Generally they should be healthier and more financially secure than their parents at retirement. What will their expectations and needs be?

Meeting the Challenge of Our Aging Society

It must be stressed that although the growth of the 65+ segment in our society appears startling–more than doubling to 20 percent by 2021–this growth should be viewed in a broader perspective. Ontario's elderly now form 10 percent of the population compared to 12 percent in Saskatchewan and 18 percent in the United Kingdom. These places and Canada share the same concerns and we are learning from their experiences.

The challenge is to maintain, and when necessary, improve programs and services that ensure the care and comfort of our elderly. The challenge can be met through innovation and planning both by the government and by those who have retired or who plan to celebrate their 65th birthdays as Ontario residents.

The major impact of demographic change on the Province will be in health and social services. The impact on income support for the elderly is, of course, important to the Province, but of greater significance to the Federal Government. This is because the Federal Government carries the largest responsibility in the total income assistance package.

Although the task force makes a number of recommendations for action, the Ontario Government is not faced with an immediate requirement for major program changes to respond to demographic shifts. The impact will be more noticeable in the late 1980's and early 1990's and thus there is time to prepare. The overall thrust of Task Force on Aging recommendations can be summarized as follows. The government should:

- continue to encourage use of personal, family and community resources to meet the challenge of aging;
- continue to encourage development of lower cost alternate forms of health care;
- continue efforts to encourage the most economical use of existing institutional and community resources;
- evaluate evolving economic and service trends in order to anticipate needed program changes; and
- respond selectively to future needs of the elderly in recognition of the improved situation of the 'average' elderly, and the shifting character of the 'future' elderly.

A Profile of the Elderly

The title of this report—The Elderly in Ontario: An Agenda for the 80's—suggests a planning horizon for responding to the Task Force's recommendations. Fortunately, the Ontario Government is not faced

with an immediate requirement for major program changes to respond to demographic shifts. The Task Force believes that the future challenge of our aging society can be met by initiating appropriate planning now and throughout the next twenty years.

This report looks at the past, present and future lives of Ontario's elderly. We hope this document will be a useful resource for all persons concerned with the aged.

A synopsis of task force recommendations begins on page 00. Details of the considerations and the statistical materials leading to the recommendations are contained in the four policy review sections beginning on page 00.

(Please note that all expenditures are expressed in 1980 dollars unless otherwise indicated. All statistics and graphs refer to Ontario unless otherwise stated.)

For the purposes of this report, the Task Force on Aging defines 'elderly' as persons 65 years and older. As is usually the case with such generalizations of convenience, the task force found that the individuals in this segment are a diverse and active cross-section of the population. In Ontario, the elderly constitute about 10 percent of the total population, or 840,000 persons. This compares to 12 percent in Saskatchewan, 10 percent for Canada and 18 percent for the United Kingdom.

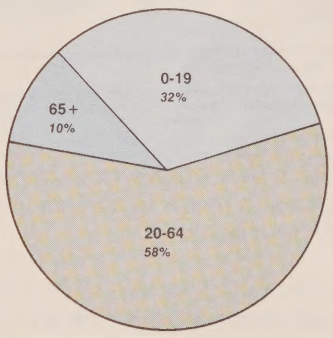
Like the population at large, the vast majority of the elderly live independently in the community and are engaged in a full range of social activities.

Figures 1 and **2** show the demographic characteristics of the elderly in the population and their use of government programs which provide additional support such as assisted housing and long-term residential care services.

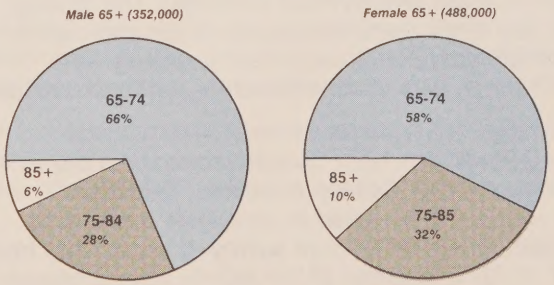
Figure No. 1

POPULATION PROFILE (1980)

The TOTAL POPULATION (8,640,000)



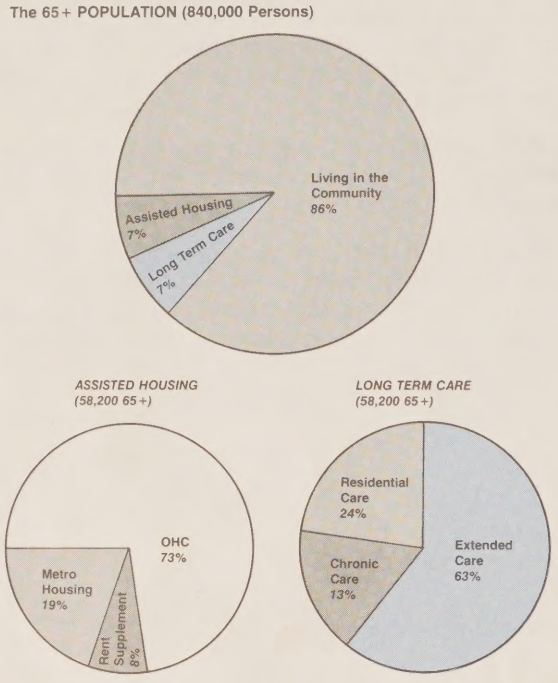
The 65+ POPULATION (840,000)



Source: Treasury and Economics: Statistics Canada, 1978

Figure No. 2

ASSISTED LIVING ARRANGEMENTS OF THE ELDERLY (1980)



- Assisted Housing is provided by Ontario Housing Corporation, Metro Housing Co. Ltd., and through rent supplements.
- Long Term Care is provided by Homes For The Aged (Residential and Extended Care), Nursing Homes (Extended Care), and Hospitals (Chronic Care).

Age is, however, a very important distinguishing factor in the following respects: income, social situation, health and housing.

Income

By age 65, close to two-thirds of the working population has retired. Between 65 and 70, most of the remaining population will retire. (The figures for 1978 show only 12 percent of the 65+ population received employment earnings.) The elderly, thus, rely more than the majority of the population on contributory pensions, personal savings and investments, plus income transfers from government.

Generally, real incomes of the elderly over the decade ending in 1980 have improved with the incomes of other Ontario residents. This steady improvement is revealed in data from a Statistics Canada consumer finance survey. It shows that from 1971 to 1977, incomes of the elderly have increased by about 20 percent (in 1971 dollars) compared to an increase of about 9 percent for the population as a whole.

Social Situation

Most of today's elderly reached adulthood before the Great Depression and certain characteristics of the 65+ population reflect the social conditions of early Ontario. For instance, more than one-half have less than Grade 9 education.

Generally, they are living longer, are healthier, better educated and more independent than the previous generation of elderly. Much of the credit for their increasingly active and fruitful lives goes to the elderly themselves, and to extensive informal support from family and friends. In addition, government programs and policies have significantly assisted them in remaining active and independent within the community. These government programs have provided a range of services to that minority of the elderly who, because of increasing disability associated with aging, are no longer able to cope without assistance.

Women constitute the majority of elderly, about 60 percent, and tend more than men to be dependent on government assistance. (In 1980, close to two-thirds of the 75+ population were women.) Elderly women are particulary dependent on public pension plans because they were not customarily in the work force during their 'working' years.

More elderly women than men are unmarried (63 percent compared to 27 percent for men) and are living alone (25 percent compared to 11 percent for men).

Health

Two-thirds of the elderly lead fully independent lives. As the elderly grow older, however, especially after age 75, their health begins to show signs of decline. They begin to be afflicted by chronic ailments related to the aging process. Among the elderly, mental health sometimes appears to be a problem, but special attention is required for only a few.

Close to two-thirds of the elderly are in the 65 to 75 age range. This 75+ segment, however, utilizes health and other resources to a much greater degree than the rest of the elderly. In 1980, there were 323,000 persons in the 75+ age group.

Housing

About 86 percent of Ontario's elderly live independently in the community. Two-thirds own their own homes, most of which are mortgage free. The minority of the elderly who do need help, receive government assistance with housing or long-term residential care.

(See Appendix C for statistical data.)

Range and Growth of Provincial Government Programs

During the 10 years ending in 1980, provincial expenditures increased 600 percent, from $319 million to $2,135 million. During the same decade, the elderly population increased 34 percent. It was a period of dramatic growth, growth that reflected the introduction of new programs, the concept of universality and a significant increase in the availability of service.

In general, provincial programs have had three major thrusts:

- to encourage and support the elderly to remain independent in the community;
- to protect the elderly from those expenses associated with aging, such as high health costs; and,
- to provide care for the minority of the elderly unable to live in the community.

Government programs for the elderly were grouped by the task force under the following headings: Health Services, Community Services, Long-Term Care and Income Support. (See Appendix A for details.) A summary of the programs follows.

General Health Services includes:

General Hospital Services
- patient care services of public hospitals (excluding chronic care)

Physician Services
- private practitioner medical services

Community Services includes:

Home Care
- a coordinated program of home health services (e.g., nursing, physiotherapy) and related allied services (e.g., homemaking)

Home Support
- four specific programs, which cover support to daily living and related social activities (e.g., meals-on-wheels, elderly person centres, home maintenance, etc.)

Long-Term Care includes:

Residential Care (Homes for the Aged)
- provision of supervised accommodation in homes for the aged

Extended Care (Homes for the Aged, Nursing Homes)
- nursing and personal care in a residential setting of a nursing home or home for the aged

Chronic Care (Hospitals)
- rehabilitation oriented continuing care program in health facility (including chronic units of hospitals and chronic hospitals)

Income Support Includes:

Tax Grants
- grants to offset cost of (a) sales taxes, (b) property taxes

GAINS-A
- income supplement to the elderly

OHIP Premium Waiver
- waiver of health insurance premiums for 65+

Drug Benefit
- free prescription drugs available to the elderly

Assisted Rental Housing
- rent-geared-to-income senior citizen housing (provided by public, non-profit and private corporations).

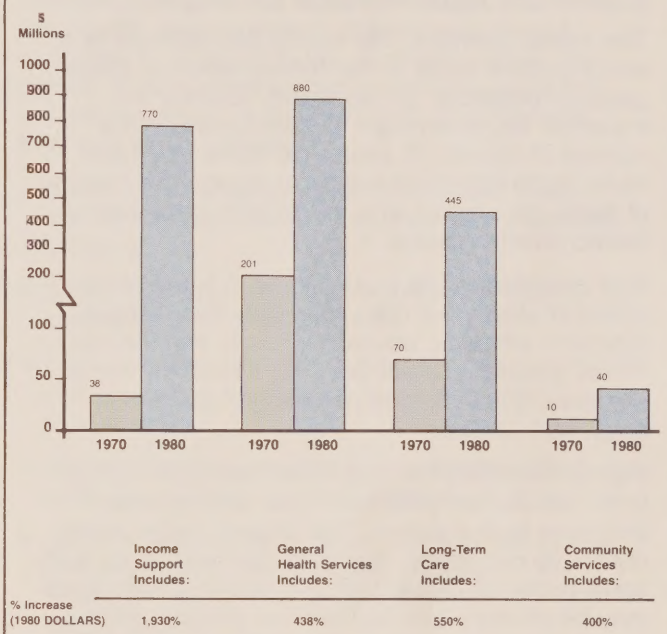
Note: Since this report was written, the Temporary Home Heating Grant was introduced which provides additional financial assistance.

Figure 3 summarizes the growth of expenditures on programs for the elderly. It must be noted that the level of spending on community services is explained in part by the relative 'newness' of the programs and also by the lower unit cost of these services.

Figure No. 3

RANGE AND GROWTH OF GOVERNMENT PROGRAMS FOR THE ELDERLY

(1980) $)



	Income Support Includes:	General Health Services Includes:	Long-Term Care Includes:	Community Services Includes:
% Increase (1980 DOLLARS)	1,930%	438%	550%	400%

During its review of the range and growth of programs, the task force members were impressed by:

- the ways in which past, present and future generations of the elderly differ from one another in terms of circumstances and expectations;
- the interactive nature of programs and the relatively limited knowledge available about the significance of this interaction; and,
- the fact that most of the present programs for the elderly were introduced during the 1970s and their 'newness' makes it difficult to predict future trends.

Demographic Growth and Expenditure Implications for Existing Programs

Demographic Trends

The increasing longevity of our population and the general decline in births is leading to significant shifts in the makeup of our society. This demographic shift will accelerate until it peaks around the year 2021, as the Baby Boom generational bulge starts to enter old age. By 2001, the elderly will constitute 14 percent of the population and by the year 2021, 20 percent. **Figure 4** shows population growth to the year 2021 and **Figure 5** shows the growth of the elderly population over the same period.

Expenditure Implications for Existing Programs

The overall growth of the elderly population is only one important factor in the consideration of future costs for programs for the elderly. Equally as important for government is the increase in the number of elderly, 75 years and older, who have more of the infirmities related to aging. The majority of these are women who, historically, have had limited private income.

Also important is the probability that future generations of elderly will differ markedly from today's elderly in attitudes, education, health and income. Future generations will likely have different needs, demands and utilization patterns for goverment-supported services.

Figure 6 couples the population distribution projections with current patterns of use of government programs by the elderly. The projections in current dollars do not appear alarming. If, however, an additional factor for inflation were included, government may be severely strained to meet present commitments in the next decade. What makes these linear projections somewhat less than definitive forecasts, however, are the assumptions on which they are based, namely:

- that future generations of the elderly will be the same as the present generation of elderly (i.e., health status, income, etc.); and,
- that historic patterns of utilization will remain constant (i.e., 34 percent of acute hospital beds and 87 percent of institutional long-term care beds are used by the 65+).

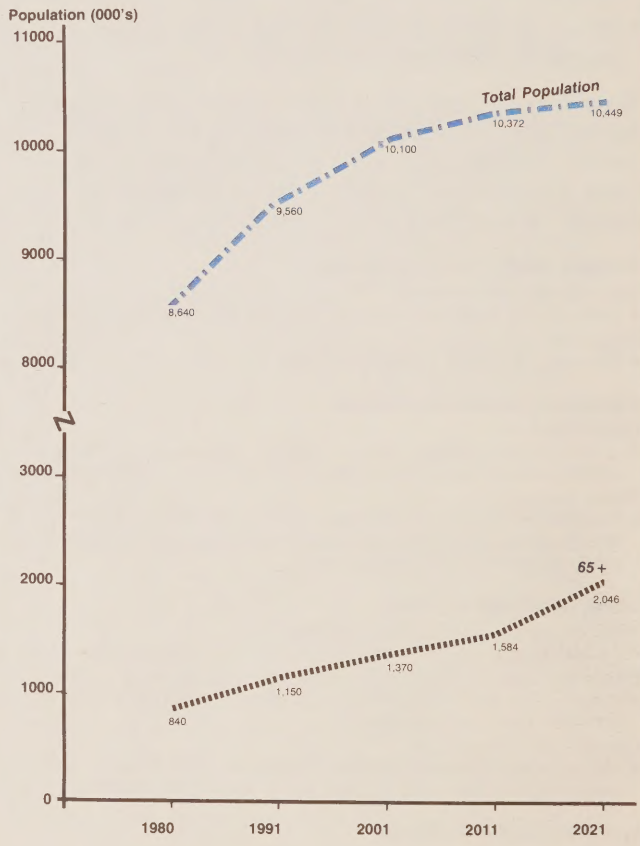
The spending forecasts **(Figure 6)** in the Income Support and General Health categories are primarily to meet the growth in absolute numbers of the elderly. As incomes of the elderly improve over time, with the phase-in of the Canada Pension Plan which applies to all elderly, selective income programs will decrease in size. Continued high inflation, however, could create demands to enrich universal programs, such as tax credits. There will be pressures on general health services if the trend toward increasing use of hospital services continues. Patterns of use will likely change, however, with the continuing development of lower cost alternatives to general hospital services.

In the Long-Term Residential Care and Community Services categories, the expenditure forecasts in **Figure 6** reflect:

- the increasing number of persons 75 and older in frail health; and,
- the extension of service availability to all areas of the province.

Figure No. 4

ONTARIO POPULATION TO 2021

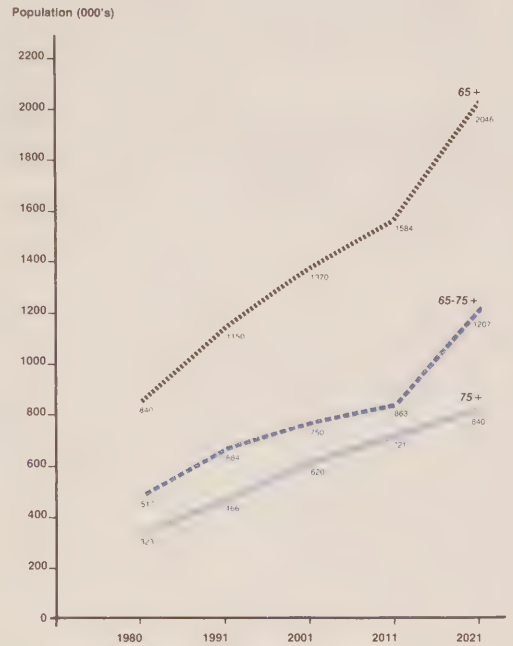


ASSUMPTIONS:
- Low Fertility
- 30,000 Net external migration

Source: Treasury and Economics; Statistics Canada, 1978

Figure No. 5

ONTARIO ELDERLY POPULATION PROJECTION TO 2021



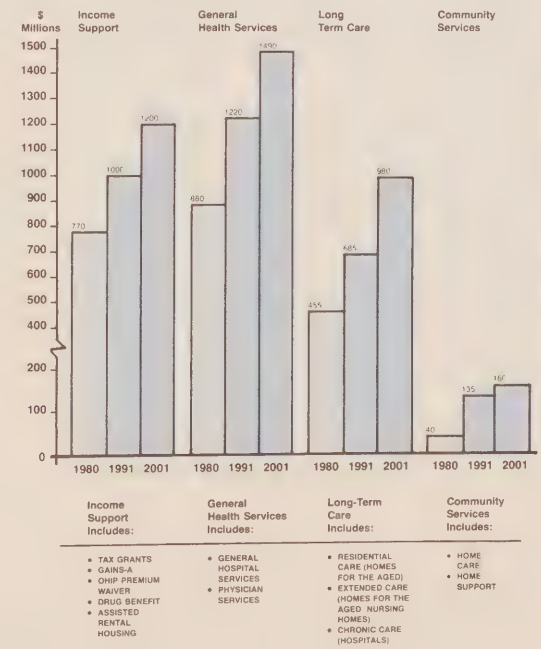
ASSUMPTIONS:
- Low Fertility
- 30,000 Net external migration

Source: Treasury and Economics; Statistics Canada, 1978

Figure No. 6

PROJECTED PROVINCIAL EXPENDITURE DIRECTED TO THE ELDERLY TO 2001

(Based on Current Utilization Patterns) (1980 $)



Income Support Includes:
- TAX GRANTS
- GAINS-A
- OHIP PREMIUM WAIVER
- DRUG BENEFIT
- ASSISTED RENTAL HOUSING

General Health Services Includes:
- GENERAL HOSPITAL SERVICES
- PHYSICIAN SERVICES

Long-Term Care Includes:
- RESIDENTIAL CARE (HOMES FOR THE AGED)
- EXTENDED CARE (HOMES FOR THE AGED NURSING HOMES)
- CHRONIC CARE (HOSPITALS)

Community Services Includes:
- HOME CARE
- HOME SUPPORT

In general, total real expenditure growth should moderate from the previous decade because it is likely fewer new programs will be introduced.

During the past decade, the elderly in general have benefitted dramatically from programs and services from government. There remain, however, certain groups in need of attention. They are the single, elderly female, and the elderly living in remote, sparsely populated areas.

Implications for Government

The government is not faced with major and immediate requirements to change established programs to respond to the population shifts. The impact of demographic change will be cumulative and more noticeable beyond 1985. The Province thus has an opportunity to:

- continue to encourage use of personal, family and community resources to meet the challenges of aging;
- continue to encourage development of lower cost alternate forms of health care;
- continue efforts to encourage the most economical use of existing institutional and community resources;
- evaluate evolving economic and service trends in order to anticipate needed program changes; and,
- respond selectively to future needs of the elderly in recognition of the improved situation of the 'average' elderly, and the shifting character of 'future' elderly.

Access to Information – Planning for the Future: Personal and Governmental

Current Programs and Policies

Provincial commitment to its senior citizens is expressed in 16 pieces of legislation and 25 programs which are directed to the elderly. Access to these programs is provided through a complex network of provincial, municipal and voluntary agencies.

In reviewing these programs and service networks, it became apparent that:

- the range and complexity of services to the elderly has increased;
- the impact of current programs and planned initiatives often involves implications for several ministries; and,
- the future elderly population will likely exhibit characteristics and attitudes different from the current elderly which may lead to changes in service requirements.

Impact of Demographic Change

A number of issues have arisen with respect to information needed by the elderly for personal decision-making and by the goverment for longer range planning and research.

Need for Program-Related Research

Given the prospect of changed service requirements related to changes in the 65+ population, it will be important to monitor the characteristics of this population and factors contributing to service demand.

Research and evaluation of current programs require attention in the light of current trends and changing attitudes. Examples of issues that should receive early examination are the cause of increased use of the health care systems by those more than 65 years, and the impact of community services on the demand for institutional care.

Access to Information for the Elderly

Given the range and scope of services to seniors and the varying needs of the elderly, it is understandable that problems may occur in locating specific information to meet particular problems. As an initial step to assist seniors, the Province has published a *Guide for Senior Citizens.* In the future, it will be important to strengthen the channels of communication between the many offices and agencies which have dealings with the elderly.

Interministry Coordination

New mechanisms are required to facilitate interministry coordination in policy development for programs for the elderly. The task force is proposing an Office on Aging as one such mechanism.

Planning for Retirement

Although government programs may provide a basic standard of living for those now 65 and older, it will still be important for those in the middle years to prepare for their retirement both in social and in financial terms.

While the advantages of pre-retirement planning of financial and personal matters are well established, individuals continue to overlook such planning. Some of the advantages of planning well in advance of retirement include:

- improved morale and health before and after retirement;
- reduced anxiety about retirement; and,
- improved financial situation in retirement.

At present, the provision of pre-retirement education is in its infancy. School boards, community colleges and private agencies are beginning to enter the field. Future development of pre-retirement education is at this time limited by scarcity of qualified leadership and resource materials as well as by a certain reluctance on the part of people in general to face the fact that they, too, are aging.

Conclusions

In response to these issues, the Task Force suggests consideration be given to the following initiatives:

An Office on Aging

The Office on Aging would serve as a central reference point for seniors and facilitate policy coordination.

The Office on Aging would:

- assist line ministries to improve information availability for seniors;
- provide a central point of contact to assist in information dissemination;
- encourage interministry coordination in policy matters, acting as support to interministry task forces; and,
- foster interministry research

Policy and Program Research Related to the Elderly

The ministries should review research needs and priorities and establish a mechanism for identifying priorities on an interjurisdictional basis, and for reviewing and approving proposals.

This initiative would:

- place increased priority on research;
- ensure coordinated use of resources; and,
- improve the information base for consideration of future options.

Planning for Retirement

The Province should take a leadership role in promoting pre-retirement planning through support of:

- development of appropriate resources—training of course leaders and preparation of resource materials, etc. and,
- a promotional strategy directed at those aged 40+ with those nearing retirement receiving first priority.

Recommendations

Based on the above conclusions, the Task Force on Aging recommends that:

1. The Province should place a high priority on early establishment of an Office on Aging.

Ministry: *Secretariat for Social Development**

2. The Province should place a high priority upon policy and program research related to the elderly.

Ministries: *Secretariat for Social Development*
Community and Social Services
Culture and Recreation
Education
Health
Municipal Affairs and Housing

3. The Province should promote the benefits of, and improve the access to, pre-retirement education across Ontario by providing initial public support for:

- the development of appropriate resources—training of course leaders, preparation of resource materials; and,
- a promotional strategy directed at those age 40+ with an emphasis on those nearing retirement.

Ministries: *Culture and Recreation*
Civil Service Commission
Education
Labour

*Ministries identified as having key responsibilities in areas covered by each recommendation are italicized.

General Health Services

Current Programs and Policies

The Provincial Government provides through the health insurance program access to a comprehensive range of *general health care benefits.* These general health benefits include *fully subsidized physician services, general hospital, emergency health care, and drug benefits.**

All these services are fully subsidized through the Ontario Health Insurance Plan (OHIP), which covers all hospital and physicians' services, and through the Ontario Drug Benefit Program, which underwrites the cost of prescription drugs. These programs came into effect in 1972 and 1974 respectively.

In reviewing current provincial policies and programs relating to health care, it became apparent to the task force that provincial priorities have been:

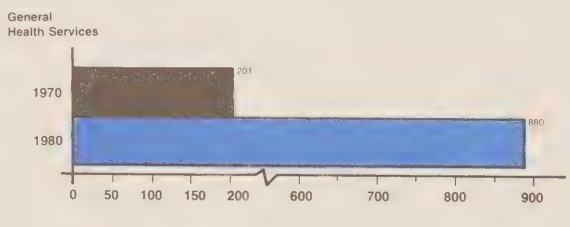
- provision of excellent quality general health care to the elderly;
- relief of the financial burden associated with illness;
- provision of alternatives to inpatient care including outpatient services and home care and,
- increased reliance on chronic hospitals and nursing homes to care for those needing long-term support.

The evolution of these policies has been influenced to some degree by an increasing concern over the cost implications of current trends. **Figure 7** summarizes the growth in general health expenditures to the elderly.

Figure NO. 7

GROWTH IN GENERAL HEALTH EXPENDITURES TO THE ELDERLY 1970 - 1980

(Millions in 1980 Dollars)



- General Health Services include General Hospital Services (excluding Chronic Care) and Physician Services
- In the 1970's, General Health Expenditures for the elderly increased 338%. In the same period, the elderly population increased by 34% (627,000 to 840,000)

*The drug benefit program is reviewed in the *Incomes Section.*

Data on the use of these services indicate that persons over the age of 65 are much heavier users, on average, than are individuals in other age categories. In 1978, for example, (the latest year for which such statistics are available), the per capita rate of use of physicians' services by elderly persons was double the rate for the population as a whole; in the case of hospital services, it was three times the population rate. (The average per capita cost of health services covered by health insurance for the elderly is $1,650 a year in 1980 dollars.)

The health problems facing the elderly do not appear to have changed considerably in recent years. The leading diagnoses for which elderly persons were hospitalized have remained virtually unchanged since 1970. The primary health problems of the elderly remain chronic in nature; especially important are diseases of the circulatory system. The major current difference, however, is that more elderly persons are living longer and, consequently, develop these chronic health problems.

In recent years, in an effort to respond to the wishes of the elderly to be maintained in their own homes as long as possible, the Province has introduced acute and chronic home care programs. Additional programs have sought to address the special needs of the chronically ill through greater utilization of extended and chronic care facilities, thus making general hospitals more available for the care of acutely ill patients.

The escalating costs of providing general health services to the elderly are a matter of some concern to the government as a whole. Between 1970 and 1980, provincial expenditures on general health care for the elderly increased by over 300 percent to $880 million. Over the same period, the number of persons over the age of 65 rose by only 34 percent. This growth in costs represents a significant increase in the per capita utilization of general health services by the elderly.

Impact of Demographic Change

The projected growth in the numbers of elderly given their relatively high utilization of health services is of significant concern. The development of lower cost alternatives such as home care have begun to address this situation. In implementing changes in the general health care system, the Province faces the following constraints:

- general health care is directed to all age groups, including the elderly, and focuses on acute care. The present orientation of general health care must shift to meet the more chronic/maintenance needs of the elderly;

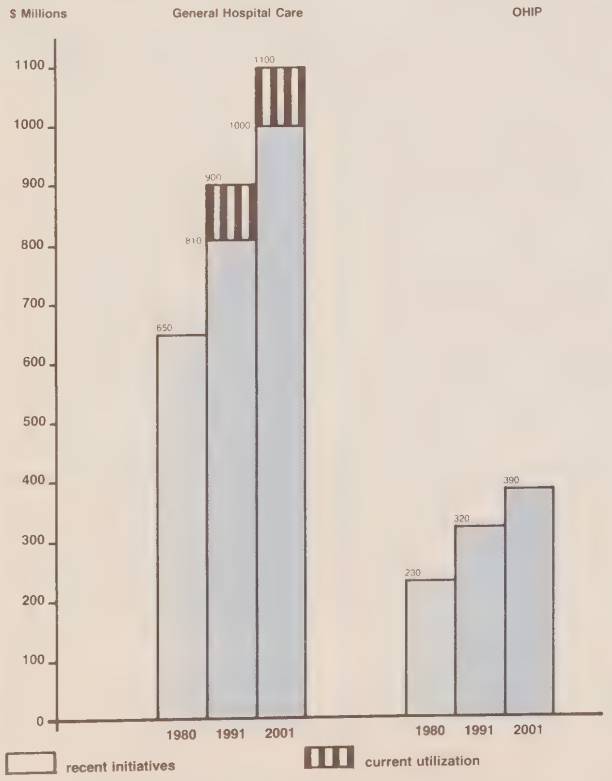
- compared to general health care, community services will take time to develop and consequently the full impact of these alternatives will not be realized in the short term;
- linkages between general health care and community support services are not fully developed. The development of placement coordination services has begun and stronger linkages with public health are needed; and,
- knowledge of the factors accounting for the increasing utilization by the elderly is limited and fragmentary.

Using available information, the task force has estimated future expenditure growth in general health services to the elderly as follows:

- based upon current utilization of services,the Province would face a projected increase of almost 70 percent in expenditure on general health services to a total of close to $1.5 billion in current dollars by 2001; and,
- current measures to moderate the use of acute facilities by the chronically ill should reduce expenditure growth, leading to a probable increase of almost 60 percent in general health expenditures for the elderly. Regardless of such changes, the magnitude of the dollars involved will remain of a high order.

Figure No. 8

PROJECTED GENERAL HEALTH CARE EXPENDITURES TO 2001
(For the Elderly) (1980 $)



ASSUMPTIONS:

- Impact of recent initiatives–10% reduction in demand for Hospital Care. This is a 1% decrease per annum.

Figure 8 illustrates the 60 and 70 percentage increase projections. These projections do not incorporate a factor for inflation, which will magnify the impact of the growth in this sector.

Conclusions

The general health care system is in transition and, consequently, the full implementation and impact of these new policies has not occurred. Nonetheless, it appears that general health care costs associated with the elderly in the medium term will continue to escalate, though efforts to redirect service provision to community care and long-term care should temper the extent of the growth in costs, particularly regarding acute hospital care.

At present, general health services for the elderly are provided largely through conventional channels: physicians' offices and general hospitals. Recently, however, experiments have been undertaken in providing services through other facilities, such as day hospitals, outpatient clinics, and community agencies. If alternatives such as these can be developed to serve a higher proportion of elderly patients, the pressure upon the general health system would be greatly eased. At the same time, elderly patients should benefit from a stronger focus upon their particular needs.

While concern exists about the impact of present trends, given the even greater number of 75+ elderly requiring services in the future, the task force feels time is still available to assess the impact of recent efforts to redirect the elderly from acute hospital care and to experiment with demonstration projects in innovative health care before considering any major changes in policy.

Recommendations

The task force, therefore, recommends that:

4. The Province should continue to support alternatives to acute hospital care, with priority on long-term care and community services.

Ministries: *Health*
Community and Social Services
Municipal Affairs and Housing

5. The Province should support development of demonstration projects in innovative health care for the elderly (e.g., day programs, outpatient programs and community based health clinics), and in applied research related to the elderly and their utilization patterns.

Ministry: *Health*
Community and Social Services
Municipal Affairs and Housing

Community Services and Long-Term Residential Care

Current Programs and Policies

The majority of Ontario's elderly citizens are able to live active and independent lives in the community. A minority, however, have difficulty coping on their own. These people have physical impairments and chronic conditions which limit their ability to carry out crucial tasks of daily living. Available evidence indicates that about 30 percent of the elderly constitute this minority.*

Voluntary programs and the family have been major sources of support to this group, and to the 'well' elderly. The range of voluntary and self-help programs is wide and includes senior citizens' clubs, elderly persons' centres, family service bureaus, friendly visiting, and recreational/educational programs.

An important current initiative is the promotion of intergenerational programs in secondary schools. Through these programs, seniors can contribute to the learning experiences of youth, and youth can develop skills and awareness by helping seniors.

Programs to assist individuals to remain in the community include:

- chronic home care. This has just been introduced by the Ministry of Health, and provides visiting nursing services and necessary allied services such as those of homemakers and physiotherapists, in the home.
- home support services, which provide help to approximately 65,000 elderly people. Under the auspices of the Ministry of Community and Social Services, these services assist with the tasks of daily living and with the social-recreational aspects of living. They include homemakers, meals-on-wheels, home maintenance, transportation, friendly visiting, security checks and elderly persons' centres.

Programs to provide a sheltered environment for those unable to remain within the community include:

- residential care, in homes for the aged, which provides supervised accommodation and minimal nursing supervision (Level I Care) to 14,200 elderly people;
- extended care, in nursing homes and homes for the aged, which provides a modified level of nursing care (1½ hours per day) (Level II Care) to 36,500 elderly people;
- chronic care in public hospitals and other health facilities, which provide intensive nursing supervision (Level III Care) to 7,500 elderly people.

*Health and Welfare Canada. *Disabled Persons in Canada,* June 1980, page 7.

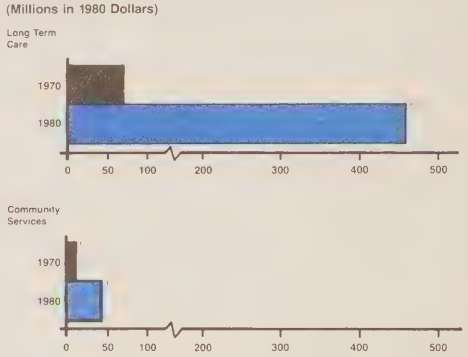
Community services programs are of fairly recent origin. Nonetheless, the expenditures for these community-based programs have increased fourfold in the past decade, from $10 to $40 million. In passing it should be noted that expenditures for institutional care have increased 5½ times, from $70 to $455 million over the same period, while the actual number of elderly people has increased only fractionally. It might be argued that if additional support were provided to family and voluntary support services, this ratio of institutional to community services could be reduced.

Figure 9 illustrates the growth in long-term care and community services to the elderly.

Figure No. 9

GROWTH IN LONG-TERM CARE/COMMUNITY SERVICES TO THE ELDERLY 1970 - 1980

(Millions in 1980 Dollars)



IN THE 1970s, EXPENDITURES ON THE ELDERLY IN THIS AREA INCREASED 512%.

In the same period, the elderly population increased by 34% (627,000 to 840,000 persons).

THIS EXPENDITURE GROWTH REFLECTS:

- The introduction of the Extended Care Program in 1972.
- The priority placed on long term care to reduce the pressure on Acute Care beds.
- The expansion of Chronic Home Care is an important new priority for the 1980's.

The result of the sizeable developments in both the institutional and the community sectors has been a notable increase in the range of options available to the elderly and in the absolute level of services available per capita.

The Province has developed over the past several years a comprehensive set of policies regarding long-term care of the elderly which:

- encourage the active elderly population to remain within its normal community settings and retain the optimum degree of independence.(through income support, tax grants, free drugs/OHIP, home care/ home support, etc)
- provide subsidized accommodation of a non-institutional nature for those whose incomes and/or circumstances preclude the above.(Ontario Housing Corporation subsidized apartments)

- provide institutional care primarily for those whose health and/or personal care needs exclude or prevent application of community alternatives. (chronic hospitals, nursing homes, homes for the aged.)

Government policies have evolved in part as a response to needs identified by constituent groups. In addition, the government has attempted to direct government support toward assisted independence within the community.

While this strategy would appear to have widespread support, it is new and has not been fully implemented across the province. These new policies have affected existing services in ways which have blurred the historical distinctions between programs. As a result, the following concerns are apparent:

- the development of programs such as chronic home care and home support which are designed to support the elderly in the community at large have undoubtedly improved the quality of life of many of the elderly and also allowed them to defer or avoid the need for more intensive and more costly services. At this time mechanisms to offer these programs in combination are few, and their combined impact has not been subject to much evaluation;
- the development of subsized housing has reduced much of the demand for more intensive residential care, as provided by homes for the aged, and allows the elderly resident a greater degree of independence. The potential of home/health support packages is beginning to be explored and more extensive use of home/health support packages may be possible;
- the distinction between health and social service programs appears to have eroded in recent years. It is becoming difficult to distinguish between many of the facilities and their clientele other than by the sponsoring ministries.

Impact of Demographic Change

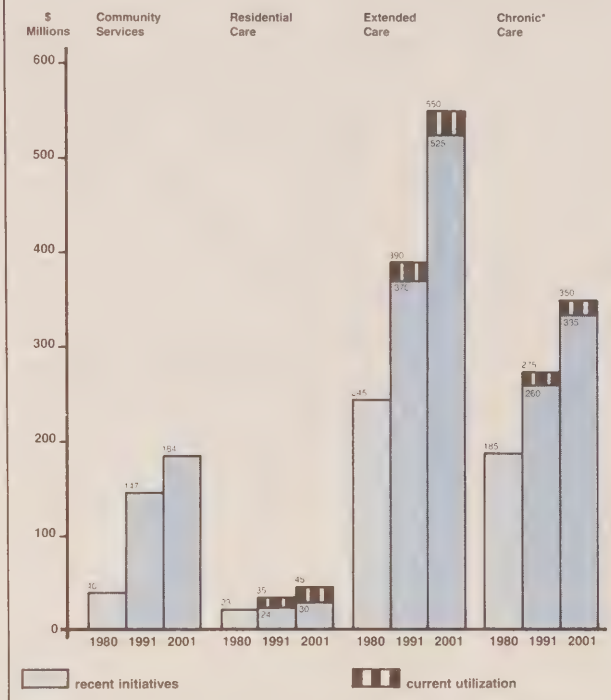
The projected increases in the number of elderly who may require community services and long-term institutional care, and the costs entailed in providing these services will be a concern in the future, particularly given the high current use of the institutional care services.

As well, the relatively recent emphasis on the development of community based programs has meant that these programs have only recently begun to affect the more historic institutional services in terms of client and professional attitudes and demands. Thus their potential for substitution can as yet only be estimated. Based upon review of available information, the task force has estimated the probable future expenditures for these services.

Figure 10 illustrates this projection which takes into account the likely impact of current measures to improve service utilization. The projection shows:

Figure No. 10

PROJECTED LONG-TERM CARE COMMUNITY SERVICE EXPENDITURE TO 2001 (For the Elderly) (1980 $)



• • It is assumed that recent initiatives to improve the utilization of acute care will lead to increased use of Long Term Care, in turn offset by the expansion of community services. The impact of these measures is derived from review of 1979-80 Accommodation Studies and Reports on Home Care.

* Additional Chronic Care requirements may be necessary to carry 'Heavy Extended Care' patients. No consideration has been given to this factor in the calculations.

- a moderate increase in the use of long-term care/community services to relieve pressure on acute care; and,
- a shift to the use of community services from institutional long-term care, with the introduction of chronic home care.

Our estimates, therefore, show the prospect of continuing increases in long-term care/community services. Over the next 20 years, expenditures in this area may more than double as follows:

- from 1980-1991, the task force sees moderate growth in long-term institutional care (+33 percent) and a marked growth in community services (+270 percent). Community services will involve a relatively small amount of dollars as the current base is small, when compared to the base for institutional care;

- from 1991-2001, the task force sees moderate growth in community services of approximately 30 percent and an increased growth in institutional long-term care of about 50 percent, resulting from the increase in the 75+ age group.

Conclusions

The task force, while endorsing the recent emphasis on community-based care, noted the following issues:

- The full range of community-based services is not yet in place throughout the province. Therefore not all elderly persons can take advantage of these services. As well, the full impact of these services on higher-cost institutional services is not yet fully understood;
- The need to address jurisdictional and inter-agency roles, so as to standardize the quality of care provided, effectively match the needs with services and ensure optimum cost control.

These concerns in large part reflected the relative newness of many programs. However, the impact of inflation and demographics on future provincial expenditures, even if modified by changes in attitudes and services tempering cost increases for institutional care, would seem to indicate that it is timely to ensure improvements in the cost-effectiveness of service delivery.

The task force suggests consideration be given to the following initiatives:

Home Care/Home Support Services

In order to support health promotion and maintain the elderly in the community as long as possible, the task force supports:

- the current plan to expand chronic home care to those communities not now covered. Chronic home care is a coordinated and flexible way to provide home-delivered health and related services to the elderly. The program has been extended to 21 communities (half of the home care program districts).

Impact:

- *would ensure the availability of community alternatives to institutional care to make the most use of the least costly services;*
- *would allow the elderly themselves greater opportunity to receive services in a manner that allows continued independence.*
- extension of increased assistance to basic home support services including homemaking, elderly persons' centres/day centres, family relief, and meals-on-wheels. The provincial home support programs have been under review in order to determine the future role for government assistance in these voluntary services. The Province should place a high priority upon completion of this review and initiatives to develop funding to home support services.

Impact:

- *would prevent the need for institutional care;*
- *would improve the quality of life for the elderly person while encouraging individual and community responsibility and partnership.*

Support Provision to Seniors Housing

- development of on-site packages of home health and home support services for seniors in areas with significant populations of elderly. In senior citizens' housing, there are opportunities for more economical and effective provision of community support services, and some service providers have already developed informal arrangements to support on-site service provision. In the future, as residents in the apartments become older, the residents of senior citizens' housing will require more health and social support services. The province has an opportunity to investigate alternative service models to assist these clusters of the elderly.

Impact:

- *reduce use of hospital services (e.g., emergency department use);*
- *provide substitute for continuing institutional care (especially residential/extended levels of care);*
- *provide regular monitoring of residents, leading to health promotion and early intervention with high risk individuals in the community.*

Effective Placement and Service Linkages

Current admission and assessment processes for long-term residential care are complex and involve a number of players. No one established process exists to ensure the appropriate use of available resources.

The Ministry of Health has initiated eight pilot projects in placement coordination to facilitate hospital discharge and patient return to the community. Consideration should also be given to the role of patient discharge planners and public health nurses in the process of assessment for continuing care.

Impact:

- *would allow for clear means of access to services for client;*
- *would improve utilization of available resources.*

Local Planning for Services to the Elderly

In a number of communities, considerable local interest and support exists for collaboration in local planning for health, social and housing services for the elderly. In the future, it will be increasingly important for local planning to emphasize the least costly alternatives, many of which involve funding by more than one agency.

Effective local planning should involve health, social, and housing agencies. Consequently, the Province should consider strengthening local initiatives in planning for seniors in their communities.

Impact:

- *would ensure optimal use of available resources at the local level;*
- *would encourage use of least costly alternatives, in particular community options; and,*
- *would co-ordinate shelter development for the elderly.*

Northern/Remote Communities

In small communities in the north it is difficult to provide a full range of services for the elderly, whether community or institutional, because of small numbers and great distance. Consequently, elderly residents have often had to move away from family and friends to obtain appropriate services. The Province should seek to improve the range of services in small communities particularly in Northern Ontario.

Impact:

- *would ensure that a range of services is provided in the small communities;*
- *would minimize the need for the elderly to leave the community for health maintenance/long-term care.*

Long-Stay Institutional Care

Various reports over the past years have examined the similarities and differences in clientele, standards, funding approaches, quality of care and services provided in homes for the aged and nursing homes and, latterly, chronic hospitals. These reports have often recommended either greater standardization, or integration under one ministry as a solution to these differences. However, no report has indicated precisely whether the impact of the above on the users, or on improved cost-effectiveness, would be of sufficient advantage to justify the disruptions entailed in standardization or integration. The task force's review covered many of the same issues, but again was unable to document precisely the degree to which the differences between these settings were creating problems of equity and/or cost control.

Because of the changing profile of the elderly and the range of public and private housing options now available, a review should be set up to include the following:

- a dialogue with relevant associations and jurisdictions;
- a survey of homes for the aged to determine clients' needs, current service levels and resulting costs; and,
- a survey of future policy options for homes for the aged.

Impact:

- *would determine most economical mode to meet residential care demand;*
- *would establish program features to be strengthened or modified in homes for the aged;*
- *would clarify the future role of homes for the aged relative to nursing homes and hospitals.*

After the proposed review of the role of homes for the aged compared to other providers, the Province may want to consider either greater standardization and coordination between institutional care providers; or integration of the institutional care providers under one auspices.

Housing and Community Support Options

Housing for the elderly is viewed in two basic forms. One is subsidized housing, provided by governments and the second is private homes. In view of the uncertainty of the housing market in the future, it will be important to look at the shelter needs of the elderly in a comprehensive manner.

At present elderly homeowners are usually 'asset rich' but sometimes have difficulty maintaining their own homes. In the future, shifts in income of the elderly and growth of alternative forms of shelter in the private sector may lead to new housing opportunities. The Province should continue to monitor current trends and consider:

- encouraging the conversion of large homes to multi-family dwellings which would permit the elderly to remain in a familiar environment and would provide increased cash income; and,
- private/public roles in provision of senior citizens housing.

Recommendations

Based upon the above conclusions, the Task Force on Aging makes the following recommendations.

6. The Province should continue to apply a high priority to development of home care and home support services.

Ministries: *Community and Social Services*
Health
Municipal Affairs and Housing

7. The Province should develop a strategy for the provision of coordinated on-site health and social support services to residential clusters of the elderly with initial priority to senior citizen residences.

Ministries: *Health*
Community and Social Services
Municipal Affairs and Housing

8. The Province should review current arrangements and initiatives in placement coordination and assess future initiatives to support effective placement.

Ministries: *Health*
Community and Social Services
Municipal Affairs and Housing

9. The Province should encourage coordination in local planning for the elderly.

Ministries: *Community and Social Services*
Health
Municipal Affairs and Housing

10. The Province should give priority to the development of coordinated service delivery to northern/remote communities.

Ministries: *Northern Affairs*
Community and Social Services
Health
Municipal Affairs and Housing

11. The Province should review the roles of homes for the aged in the provision of long-stay institutional care.

Ministries: *Community and Social Services*
Health
Municipal Affairs and Housing

12. The Province should undertake a general review of shelter trends for the elderly and future alternative policy options including the roles of public and private sectors.

Ministries: *Municipal Affairs and Housing*
Community and Social Services
Health
Revenue
Treasury and Economics

Income Support

Current Programs and Policies

In recent years, both the Federal and Provincial Governments have responded to the particular income needs of the elderly by introducing a wide range of programs directed both to the general 65+ population (universal) and to those with few or no personal resources (selective).

The federal role in income assistance to the elderly was shaped in the 1960s. At that time, renewed emphasis was placed upon programs to the elderly population at large by the extension of the coverage of Old Age Security (1966) and the introduction of the Canada Pension Plan (1966)*.

Since the Canada Pension Plan would not become fully operational for a decade, until 1976, the Federal Government introduced income supplementation in 1968 to guarantee a basic level of income to the elderly through the Guaranteed Income Supplement program (GIS).

In the early 1970s, the Ontario Government further strengthened income assistance to the elderly through elimination of health insurance premiums (1972), and by introducing the Sales Tax/Property Tax Assistance Program (1972) and the Ontario Drug Benefit Program (1974).

Additional assistance was also extended by the Province to the elderly at the lower end of the income scale through the Guaranteed Annual Income System for the Aged (GAINS-A), which provided additional income supplementation to the aged (1974) and the assisted housing programs (for instance, rent-geared-to-income housing).

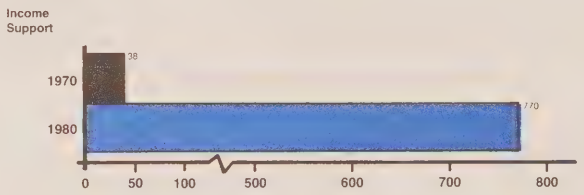
By 1980, Ontario's elderly were recipients of a wide range of benefits which helped compensate for the drop of income in retirement. Provincial expenditures in this area increased approximately 20-fold in the decade 1970-1980 (from approximately $38 million to $770 million).

Figure 11 illustrates the growth in income assistance to the elderly. The following chart summarizes current universal and income-tested programs.

Figure No. 11

GROWTH IN INCOME ASSISTANCE TO THE ELDERLY 1970-1980

(Millions in 1980 Dollars)



THE INCOME SUPPORT EXPENDITURE GROWTH REFLECTS THE INTRODUCTION OF:

- Tax Credits (1974) replaced by TAX GRANTS (1980)
- Drug Benefit Program (1974)
- O.H.I.P. Premium Waiver (1972)
- GAINS-A (1974)
- During the 1970's Income Support Expenditure for the Elderly increased 1930%
- In the same period the elderly population grew by 34% (From 627,000 to 840,000 persons)

*Note: The Task Force on Aging has not reviewed pension provisions and policies. Please refer to the report of the *Royal Commission on the Status of Pensions*.

Income Assistance to the Elderly: Universal Programs

Program	Sponsor	Budget 1980-81	Benefit Jan. 1981
Old Age Security • an indexed universal benefit (counted as taxable income)	• Federal Government	• $1,765 million	• $202.14 (single)
Tax Grant programs • grant to offset 1) sales tax 2) property tax	• Provincial Government	• $265 million	1) $50 per person 2) Up to $500 per household
Health Insurance • waiver of premiums	• Provincial Government	• $200 million lost revenue	• $240 per person
Drug Benefit Program • free prescription drugs available to the elderly	• Provincial Government	• $125 million attributable to the elderly	• dollar value not available

Income Assistance to the Elderly: Income Tested Programs

Program	Sponsor	Budget 1980-81	Benefit Jan. 1981
Guaranteed Income Supplement • an indexed income-tested benefit (not taxed)	• Federal Government	• $420 million	• $202.94 per person • $312.94 per couple
Guaranteed Annual Income System • an additional income-tested benefit	• Provincial Government	• $104 million	• $48.88 per person • $135.70 per couple
Assisted Housing • rent geared to income housing • eligibility determined by income health, and housing factors	• Federal and Provincial Government	• $154 million	• $187 average per household

As of January 1, 1981, the combined impact of the universal, income tested, federal and provincial programs is to provide a total net benefit for the low-income elderly of:

	Single	Couple
Universal programs (OAS, Tax Grant, Premium Waiver)	$3,216	$ 5,932
Income-tested programs (GIS, GAINS)	$3,022	$ 5,383
Combined value of transfer	$6,238	$11,315

In addition, all elderly persons receive free drug benefits and low-income elderly people are eligible for subsidized housing.

Generally, in reviewing current income support programs for the elderly, it appears that these programs have improved the situation of the elderly resident of Ontario in both absolute terms and in relation to their needs.

The only features related to current programs that might involve expansion of benefits would appear to be:

- the position of the single elderly persons relative to that of the elderly couple; and
- the lack of an earnings incentive for low-income elderly people.

Impact of Demographic Change

The most important factor affecting future policy on programs for the elderly is the absolute growth in the numbers of elderly people in future years. This will mean substantial increases in expenditures just to retain current levels of benefits, particularly since the bulk of current expenditures are related to 'universal' programs*. Other key factors include:

- the rate of inflation as reflected in indexed transfers;
- availability of funds (growth in Gross National Product); and,
- the growth of other private income sources and their relative impact on transfers.

While the exact impact of these variables can only be estimated, it is possible to predict that if present trends continue:

- selective, income- and needs-sensitive programs will begin to diminish in size;
- universal or less selective programs will continue to grow in size; and,
- universal or less selective programming for the aged will continue to comprise a larger portion of total income security expenditures to the elderly.

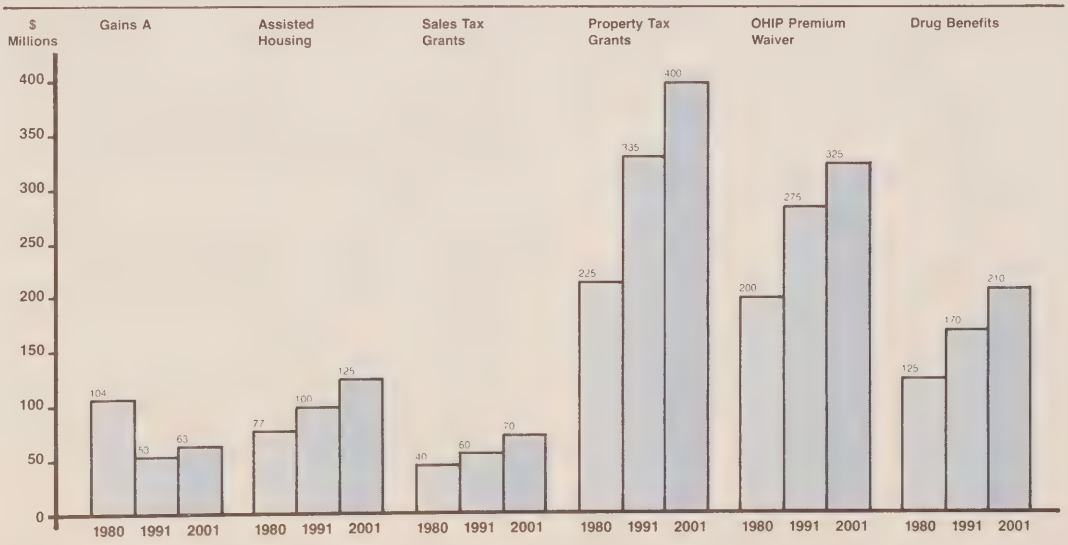
Increased private pensions and personal investments will not replace government expenditures in universal programs. These universal programs constitute the major portion of total government income expenditures to the elderly and their growth will be directly related to future population growth.

Based on available information, the task force has estimated the growth of future expenditure on income support to the elderly. From 1980 to 2001 the government could face an increase of 56 percent in income support expenditures. While universal income support programs such as the tax grants and the OHIP premium waiver will increase at an even higher rate, the selective income measures (in particular GAINS-A) are expected to decline because of an increased number of CPP recipients.

Figure 12 illustrates projected income assistance expenditures to the elderly to 2001.

Figure No. 12

PROJECTED INCOME ASSISTANCE EXPENDITURES TO THE ELDERLY TO 2001 (1980 $)



ASSUMPTIONS:

- Continuation of the current programs (Eligibility rules and benefit levels)
- Constant penetration of 65+ population (With the exception of Gains-A)
- Gains – Expenditures will decrease as more elderly receive C.P.P. payments and other retirement income.
- Availability of Housing options for the elderly through conversion of existing stock and private sector options.

In this program area, it is expected that there will be continued pressure to increase benefits to match inflation (for example, by raising the grant under the property tax grant program).

Given the nature of current programs, much of the impact of an increasingly elderly population will be felt by programs under federal jurisdiction, any change to which would require federal consent. In its own right, however, the Province is contributing significant amounts in this area and must continue to be sensitive to the changing needs of the elderly.

Conclusions

Provincial policies have significantly assisted the well-being of the elderly in retirement by specifically:

- ensuring that all elderly people will receive an adequate and guaranteed income upon reaching age 65 (GAINS-A);
- recognizing some of the additional costs associated with aging and providing relief from these costs (free drugs, free OHIP); and,
- recognizing the limited earning capacity of all elderly persons in meeting the costs of shelter (tax grants, subsidized housing).

The programs directed to the elderly that grew out of these policies go beyond other programs of government support to 'at risk' target groups such as dependent mothers. The number of 'universal' benefits, the relatively high minimum benefit levels, and the extent of indexing should be noted. These features reflect a perception by the public that the elderly should be protected from financial hardship, and that work and thrift should be rewarded in terms of additional post-retirement income available.

Short Term Initiatives

The task force suggests consideration of the following in the short term:

GAINS-A Single Rate

At present a single person on GAINS-A is guaranteed 53 percent of the amount provided to an aged couple through O.A.S, G.I.S. and GAINS-A. The single elderly person, however, has many of the same basic expenses as the couple. The Royal Commission on the Status of Pensions has highlighted this issue and recommended the single guaranteed income be increased to 60 percent of the couple rate. (In 1979, the Federal Government began recognizing the special needs of the single person on GIS by providing the same increases to singles and couples.)

Encouragement of Personal Responsibility and Part-Time Employment of Elderly People on GAINS-A

In the future, the Province will want to encourage increased self-sufficiency among the elderly. To some elderly persons a part-time job could be the key to reducing their reliance on government income supplements.

An elderly person receiving GAINS-A is, however, effectively discouraged from seeking part-time employment because program benefits are reduced on a one-to-one basis with additional earnings, i.e., benefits are reduced $1 for every $1 earned.

The Province should consider lowering the GAINS-A recovery rate on earnings. The task force suggests a program change that would enable the elderly on GAINS-A to keep $1 of every additional $4 earned through employment. The elderly on GAINS-A, thus, would be encouraged to take part-time jobs in the community.*

Long-Term Review

The universal programs receive about 70 percent of the 65+ income security budget and provide benefits to all elderly people regardless of need. In the future, increased coverage by private and public pensions should improve the general situation of the elderly. While there is no significant evidence to warrant any immediate action to change the nature of those universal programs currently in place, consideration should be given to assessing the need to maintain universal rather than selective programs. Future policy directions therefore should include consideration of:

- the degree to which government can and/or needs to continue current programs as a response to historic shortfalls in private income after retirement (personal responsibility versus public support);
- the extent to which greater 'targeting' of income programs would improve the cost effectiveness while maintaining the Province's objective of ensuring an adequate basic income for all elderly;
- the degree to which future 'enhancements' to income support programs should be considered against other possible needs of the elderly (e.g. institutional care) which more selectively meet the needs of the older person "at risk";

*The recovery rate on income under both GIS and GAINS-A has a combined recovery rate of 100 percent. While the task force supports this incentive, certain administrative difficulties have to be addressed.

- whether or not Ontario should open discussions with the Federal Government with respect to possible revisions regarding income support programs for the elderly.

The Task Force believes that the Province should begin examination of these issues and, to that end, a review should be undertaken of the income trends of the elderly and alternate policy options.

At the same time, the task force suggests that the Province should resist the introduction of further universal programs or any significant enrichment of current universal programs pending review of provincial income policies for the elderly.

Recommendations

Based on the above conclusions, the Task Force on Aging recommends that:

13. The Province should investigate the desirability of and alternative approaches to adjusting the GAINS-A guarantees to reflect the fact that income needs of single persons are greater than the needs of a couple.

Ministries: *Treasury and Economics*
Community and Social Services
Revenue

14. The Province should investigate lowering the recovery rate on earnings for GAINS-A recipients.

Ministries: *Treasury and Economics*
Revenue

15. The Province should develop a corporate position on alternative measures to increase selectivity in income assistance to the aged.

Ministries: *Treasury and Economics*
Community and Social Services
Health
Labour
Municipal Affairs and Housing
Revenue

Summary of Recommendations

The recommendations made by the Task Force indicate a planning agenda for the 80's. The Ontario Government is not faced with an immediate requirement for major program changes to respond to demographic shifts. The Task Force believes that the future challenge of our aging society can be met by initiating appropriate planning now and throughout the next twenty years.

Policy Area	Recommendation	Ministry/ies	Page Ref.
INFORMATION AND PLANNING	1. The Province should place high priority on early establishment of an Office on Aging.	*Secretariat for Social Development**	11
	2. The Province should place high priority upon policy and program research related to the elderly.	*Secretariat for Social Development* Community and Social Services Culture and Recreation Education Health Municipal Affairs and Housing	11
	3. The Province should promote the benefits of, and improve access to, pre-retirement education by providing initial public support for: • the development of appropriate resources–training of course leaders, preparation of resource materials; and, • a promotional strategy directed at those age 40+ with an emphasis on those nearing retirement.	*Culture and Recreation* Civil Service Commission Education Labour	11
GENERAL HEALTH SERVICES	4. The Province should continue to support alternatives to acute hospital care with priority on long-term care and community services.	*Health* *Community and Social Services* Municipal Affairs and Housing	13
	5. The Province should support development of demonstration projects in innovative health care for the elderly (e.g. day programs, outpatient programs and community based health clinics), and in applied research related to the elderly and their utilization patterns.	*Health* Community and Social Services Municipal Affairs and Housing	13
COMMUNITY SERVICES/ LONG-TERM CARE	6. The Province should continue to apply a high priority to development of home care and home support services.	*Community and Social Services Health* Municipal Affairs and Housing	18

Policy Area	Recommendation	Ministry/ies	Page Ref.
	7. The Province should develop a strategy for the provision of coordinated on-site health and social support services to residential clusters of the elderly with initial priority to senior citizens residences.	*Health* Community and Social Services Municipal Affairs and Housing	18
	8. The Province should review current arrangements and initiatives in placement coordination and assess future initiatives to support effective placement.	*Health* Community and Social Services Municipal Affairs and Housing	18
	9. The Province should encourage coordination in local planning for the elderly.	*Health* *Community and Social Services* *Municipal Affairs and Housing*	18
	10. The Province should give priority to the development of coordinated service delivery to northern/remote communities.	*Northern Affairs* Community and Social Services Health Municipal Affairs and Housing	18
	11. The Province should review the roles of homes for the aged in the provision of long-stay institutional care.	*Community and Social Services* Health Municipal Affairs and Housing	18
	12. The Province should undertake a general review of shelter trends for the elderly and future alternative policy options, including the roles of public and private sectors.	*Municipal Affairs and Housing* Community and Social Services Health Revenue Treasury and Economics	18
INCOME SUPPORT	13. The Province should investigate the desirability of and alternative approaches to adjusting the GAINS-A guarantees to reflect the fact that income needs of single persons are greater than the needs of a couple.	*Treasury and Economics* Community and Social Services Revenue	23
	14. The Province should investigate lowering the recovery rate on earnings for GAINS-A recipients.	*Treasury and Economics* Revenue	23
	15. The Province should develop a corporate position on alternative measures to increase selectivity in income assistance to the aged.	*Treasury and Economics* Community and Social Services Health Labour Municipal Affairs and Housing Revenue	23

*Ministry/ies italicized are key ministry/ies

Appendix A

Historical Review: Provincial Services to the Elderly, 1950-1980

Introduction

The role of the government in providing programs and services for the elderly in Ontario has changed dramatically during the 30 years ending in 1980. Up to 1950, government responsibilities ended with the provision of assistance to the aged poor. Government was mainly a regulator, not a provider. Since then a wide range of federal and provincial programs have been introduced, improving the well-being of Ontario's elderly in all aspects of daily living. This historical review explains the development and growth of the various programs and services under the following headings:

Prepared by Adults' Policy Development, Ministry of Community and Social Services, January 1, 1981.

Hospital and Medical Benefits

Overview

Over the last 30 years, the Province of Ontario has evolved from a situation in which payment of medical and hospital costs was a purely private venture to one in which universal health insurance is available and provided under governmental auspices. With regard to the elderly in particular, a small program to cover the medical costs of old-age pensioners has given way to a system of insured physician and general hospital services at a current cost to the Province of $880 million.

History

At the outset of the period under review people were universally responsible for paying their own general hospital bills. If they were indigent the costs fell back on the municipalities. Medical treatment was a purely private venture. However, the Ontario Medical Association's Medical Welfare Board pro-rated payments to doctors for treatment of old age pensioners and other indigent patient categories, out of a block grant received from the Ontario Government. The cost to the Province for medical services to Old Age Assistance (OAA) and Old Age Security (OAS) recipients exceeded $1 million by 1965.

The Province received some grant assistance toward the construction of hospitals from the Federal Government's program of National Health Grants launched in 1948. As the post-war demographic picture became clearer—a rising proportion of very young and very old who together are the heaviest users of hospitals—health facilities construction 'took off' after 1951. Investment initiatives, however, were somewhat constrained by the rigid classification into which they had to fit to be eligible for funding under the National Health Grants.

During most of the first half of the 1950's, the Province did not contribute to the day-to-day operating cost of general hospitals. The public was increasingly turning to privately-sponsored and non-profit hospital insurance plans and general hospitals became increasingly dependent on insurance payments.

As growing hospital utilization began to exert upward pressure on operating costs, the government enlarged its contribution. The Province's expressed preference at the time was to subsidize hospitals to reduce their charges to individuals rather than to increase the individual's ability to pay.

In 1956, the Ontario Hospital Services Commission was established. It was eventually to become the government's arm for administering universal hospital insurance. Ontario entered governmental hospital insurance in 1959; having been instrumental in its development as a federal-provincial plan earlier in the decade. The introduction of federally-assisted hospitalization in 1959 completed the shifting of most hospital operating costs from the private to the public sector.

The Ontario Medical Services Insurance Plan (OMSIP) went into operation on April 1, 1964, to provide free or subsidized coverage for low income people and was open on a full-premium-paying basis to all. It provided for payment of 90 percent of the Ontario Medical Association's fee schedule and was operated by the government. However, enrollment being voluntary, the field was left clear for the private plans to continue in operation.

In 1969, the Province extended the insurance plan to cover medical benefits to the population at large and, thereby, the Ontario Government entered the National Medicare Plan. In 1972, medical and hospital insurance became jointly administered under OHIP—the Ontario Health Insurance Plan. Persons 65 years or older who have lived in Ontario for at least 12 months are entitled to free OHIP coverage.

Ontario Drug Benefit Program

In 1974, the Ontario drug benefit program was introduced. Under the program, the elderly, and social assistance recipients, are entitled to free prescription

drugs listed in the Ontario Drug Formulary. Old Age Security (OAS) recipients automatically receive an Ontario senior citizen's privilege card used as identification for this program. Elderly people who do not receive OAS but who have lived in Ontario as permanent residents for 12 consecutive months are also entitled to participate in the Ontario drug benefit program. In 1980, approximately $125 million was spent on free prescription drugs for the elderly.

Community Services

Overview

The Province of Ontario has assumed a progressively prominent and innovating role in the provision of community services for the elderly.

Since its introduction in 1958, homemakers and nurses services have grown to the point where, in 1979-80, $6 million was spent by the Province and more than half of this sum was for homemakers and nurses services delivered to the elderly.

Not only did the Province provide financial incentives for the development of elderly persons social and recreational centres (there are now well over 100) but it also encouraged the development of home support services under the aegis of these centres and through special projects. Other community-based programs, such as vacation care and day care for the aged, have also been introduced.

The Ontario Ministry of Health has also been active in the community services sphere. The acute home care program, which began in the mid-sixties, involved a provincial expenditure of $15 million in the 1979-80 fiscal year while the still expanding chronic home care program, initiated in 1975, involved a provincial expenditure of $6 million in 1979-80.

Indeed, the diversity of community services now available to meet the many and differing needs of the elderly and other target groups has raised questions of coordination and financing.

History

The clearest examples of Ontario's evolution from a province in which government's primary role, 30 years ago, was that of regulator to its contemporary service-provider role are offered by the progressive development of a host of community services for the elderly.

Provincial involvement in community services for the elderly was first formalized with the introduction of *The Homemakers and Nurses Services Act* in 1958. The program operated at the discretion of the municipality and was cost-shared 50 percent by the Province and 50 percent by municipalities. Under this program homemakers and nurses visit the elderly, the handicapped or the convalescent so that they may remain in their own home and not have to enter a hospital or institution.

Homemakers may prepare meals, shop, do light laundry and cleaning or provide personal care services such as dressing. Nurses provide health care. These support services are administered by municipalities which may use their own homemakers or nurses or the services of agencies, such as the Victorian Order of Nurses, the Canadian Red Cross Society and the Visiting Homemakers' Association. Payment for these services is according to the recipient's ability to pay. There are no residency requirements except that the recipient must live in the municipality to which the application for service is made.

Amendments to the enabling legislation in 1968 provided for 80 percent of the costs to be covered by the Province and the Federal Government.

The demand and, hence, cost for homemakers and nurses services has steadily increased over time. In 1962, *The Homemakers and Nurses Services Act* was amended to permit the provision of preventive, restorative, and emergency services. This had ramifications for service utilization by the elderly. In 1961, almost 106,000 nurse visits were undertaken and over 24,000 homemaking hours were provided. A decade later the figures were 174,000 nurse visits and 824,000 homemaker hours. In the 1979 fiscal year, 133,000 nurse visits were undertaken and 1.5 million homemaking hours provided at a total cost of approximately $6 million to the Province. Since the elderly make greatest use of homemakers and nurses services, over half of the provincial expenditure was incurred on behalf of the elderly.

The Elderly Persons Social and Recreational Centres Act was passed in 1961. Its purpose was to assist non-profit organizations with costs of building and expanding social and recreational centres for the elderly. In 1966, this act was amended to become *The Elderly Persons Centres Act.* In addition to modified funding arrangements, the new legislation provided for the use of provincial funds for home support services such as meals-on-wheels, wheels-to-meals, assistance with shopping and heavy cleaning.

By 1970, municipalities as well as non-profit organizations were operating Elderly Persons Centres

(EPCs) and the provincial grant for the special home support services operated by the individual EPCs, hitherto only $5,000, had been raised to $15,000. In 1979, there were 115 EPCs in the province.

Since early 1976, the Ministry of Community and Social Services has actively encouraged the provision of home support services under the aegis of EPCs. In 1979, 40 EPCs were offering home support services for nearly 12,000 clients per month at an annual cost to the province of $437,400.

In addition, starting in 1977, there were 27 demonstration projects (Alternatives to Institutional Care) operating throughout the province. Funded under *The Ministry of Community and Social Services Act,* these demonstration projects provided a range of home support services similar to those provided by EPCs.

Other community-based programs were developed during the 1970s. Vacation care, a respite service for families who looked after an elderly family member, started as pilot projects in Niagara and Toronto in 1970. By the end of the decade, over 70 homes for the aged provided vacation care. Day care centres (serving over 600 elderly persons) and drop-in centres were operating in 33 homes for the aged at the close of the 1970s, and 157 projects or organizations, including 75 homes for the aged, were providing meal services such as meals-on-wheels.

In 1979, an additional $2 million was made available annually, for three years, under the ministry act for further development of home support services. It was recognized that it was difficult for EPCs to fund the growing home support component of care for the elderly. The additional funding was an interim measure to ensure the provision of services until the Ministry of Community and Social Services completes its current review of home support services and develops appropriate legislation for the future. At the end of April, 1980, there were 146 home support services projects either currently funded or approved for funding.

The acute home care programs of the Ontario Ministry of Health started growing in the mid-1960s with programs in Toronto, Ottawa and other southern Ontario communities. Acute home care is also oriented toward the provision of service in the home. An aged person who is covered by OHIP is eligible for acute home care if a doctor specifies that at least one professional health service, such as a nurse, physiotherapist or speech therapist, is needed. The doctor applies for such care on behalf of the patient and heads the team providing health services in a planned program of comprehensive health care at home. The program is intended for people who need specific home care for short periods. Early in the 1970s, the acute home care program became province-wide. Acute home care for the elderly cost the Province, through the Ministry of Health, $15,079,600 in the 1979-80 fiscal year.

In 1975, the first pilot projects for chronic home care were introduced in Kingston, Hamilton and Thunder Bay. This program, like the acute home care program, is available free of charge to OHIP subscribers. To qualify for the program, a doctor must specify that the patient needs a minimum of three visits from health professionals per month. It is intended to help people who need continuing care to remain in their homes. The chronic home care program is not yet available in all communities. In 1980, a commitment was made to have chronic home care available throughout the province by 1982. Provincial expenditure for chronic home care for the elderly was $6,009,800 in the 1979-80 fiscal year.

Institutional Care

Overview

The history of institutional care over the last 30 years demonstrates the Province's continued commitment toward meeting the specific needs of the elderly. The Province assumed a major role as investor-builder through the high priority assigned to sponsoring construction of homes for the aged and the raising of ceilings on the provincial share of capital costs. Between 1949 and 1969, the bed capacity in municipal homes for the aged alone increased four-fold to 14,996. In 1980, the total bed capacity of the 181 municipal and charitable homes for the aged was 27,968 and total provincial expenditure on both types of homes reached $127 million.

The Province also progressively assumed the role of service-provider. Through the extended care program, regulation of nursing homes and expansion of chronic care hospitals, mechanisms came into being that underscored the acceptance of a broader responsibility for the welfare of the aged. The shift to a larger social service role resulted in government paying large sums for services (health) that had previously been almost wholly within the private domain. Thus, between 1972 and 1980, the nursing home resident population increased by one-third to 40,247 while the provincial allocation for nursing home extended care increased more than five-fold to $139 million. (The purchasing power of the dollar in 1980 was about half of its purchasing power in 1972.) Provincial expenditure for extended care delivered in nursing homes *and* homes for the aged was $241 million in 1980 while the allocation for chronic care was a further $250 million.

History

Thirty years ago, new provincial policies were developed to facilitate public and private investment in institutional facilities for the elderly. This was prompted by three key factors:

(1) the growing proportion of elderly in the population (400,000 people, or 8.7 percent of Ontario's population, were 65 or older in 1951);

(2) the various long-term social changes, mainly related to industrialization and urbanization, which had begun to reduce the incidence of elderly persons living in extended family units, and;

(3) the post-war housing shortage.

Municipal and Charitable Homes for the Aged

The Homes for the Aged Acts of 1947 and 1949 (especially the latter) shifted substantial government resources into housing for the elderly. Ontario's traditional mode of assisting institutional investment was through grants to local authorities and fraternal, religious or other charitable organizations. The 1949 act made it mandatory for municipalities to provide and operate suitable homes for the aged, with the Province paying half of the capital cost and a proportion of the operating costs. Admission to a home for the aged was to be based on the need for care rather than financial need—a grand departure from the 'deserving poor' philosophy that animated housing provided under the old *Homes of Refuge Act* and to which a 'poor house' stigma had been attached.

The 1950 amendments to *The Charitable Institutions Act* further served to channel provincial resources into homes for the aged. The legislation provided a provincial subsidy of $1,000 per bed to private charitable organizations for constructing new buildings to care for the aged.

New legislation, passed between 1956 and 1958, provided additional incentives to municipalities and charitable organizations to upgrade and construct homes for the aged. The provincial subsidy to municipal homes was increased to 70 percent while charitable organizations were granted $2,500 per bed for construction costs and reimbursed to 75 percent of operating costs.

The legislation also recognized that segregation by type of care should be provided. Up to that time, most care was of the congregate type (no segregation for various types of care). Semi-segregated (segregated care for one class of resident, that is, bed care but other residents not segregated) and segregated facilities (full segregation for normal care, bed care, special care and married couples) were consequently constructed. The construction of semi-segregated and segregated homes for the aged reflected a sensitivity to the diversity of the elderly's needs.

The legislation referred to above stimulated an investment boom in homes for the aged; there was a dramatic growth in municipal homes' bed capacity during the 20 years following passage of *The Homes for the Aged Act,* 1949 from 3,732 beds in 1949 to 14,996 beds in 1969.

Between 1949 and 1969, $109,819,200 was spent on constructing municipal homes for the aged. The provincial grant toward this effort totalled $56,283,300. By 1980, Ontario's municipalities operated 89 homes for the aged and most of these were segregated facilities. Provincial grants toward construction of charitable homes for the aged came to $23,982,300 between 1949 and 1969. Charitable organizations were operating 92 homes, largely segregated, by 1980.

The 181 municipal and charitable homes for the aged operating in 1980 had a total bed capacity of 27,968. Total provincial expenditure reached $102 million and $25 million for municipal and charitable homes respectively.

Nursing Homes

Nursing homes had existed for many years as privately run establishments offering some types of nursing care for the elderly without governmental involvement. *The General Welfare Assistance Act* of 1958 awarded certain payments on behalf of indigent nursing home residents. These payments assured the owner of coverage for indigent patients and assured the patient of a source of payment if the costs could not be met.

Nursing homes were brought under control of the provincial Ministry of Health in 1966. *The Nursing Homes Act* of that year established operations standards for the 500 or so nursing homes then in existence.

However, the benchmark legislation for nursing homes was *The Nursing Homes Act* of 1972. It provided in considerable detail, standards by which licensed nursing homes were to be operated. At the

same time, an extended care benefit was introduced which entitled anyone requiring such care to be covered by OHIP.

Extended care was introduced largely in response to the government's concern over the high cost of hospitalization. Under this program, residents of nursing homes *and* municipal and charitable homes for the aged who needed nursing care above 1½ hours daily, but whose condition did not warrant hospitalization, were covered for most of the cost of their care within the home. As of April 1, 1972, in order to maintain its licence a nursing home had to provide at least 75 percent of residents with extended care.

In 1972, there were 30,000 nursing home residents and 82 percent of the beds licensed for extended care were being used for extended care. In 1980, there were 40,247 nursing home residents and all beds licensed for extended care were being used.

Today, extended care is funded partly by the Ministry of Health (under *The Nursing Home Act* and *The Health Insurance Act*), partly by the Ministry of Community and Social Services (under *The Homes for the Aged and Rest Homes Act* and *The Charitable Institutions Act*) and partly by a co-payment by the resident. The co-payment is tied to the Old Age Security/Guaranteed Income Supplement (OAS/GIS) rate of support and is set so that each resident will be assured a comfort allowance (personal spending money), which now is $96 per month.

In 1972, the provincial allocation for extended care for the elderly in nursing homes was $25 million. In 1980, the corresponding figure was $139 million. The total provincial expenditure for extended care in nursing homes and homes for the aged was $241 million in 1980.

Chronic Care Hospitals

Chronic care hospitals or the chronic units of general hospitals seek to provide a rehabilitation-oriented continuing care program. In addition to diagnostic services, chronic care provides skilled nursing and medical management, therapeutic services (physical therapy, occupational therapy, and speech therapy), social and recreational services, dietary services and necessary mechanical aids.

The Ministry of Health is responsible for these facilities under *The Public Hospitals Act, The Health Insurance Act* and *The Health Disciplines Act*. Provincial expenditure on chronic care was $250 million in 1980.

Other Programs – Special Home Care

The growing emphasis on providing facilities for different types of care for the elderly and some abandonment of the previous preoccupation with economies of large-scale operation in favor of the advantages of more human scales of operation resulted in the introduction of the Special Home Care Program (SHCP) in July, 1955. The SHCP sought to provide an alternative to care in a home for the aged. The program provided for care in approved private homes in the community for those who require neither bed care nor special care and who preferred accommodation in a private home to that in an institutional setting. The local home for the aged was to assume responsibility for SHCP participants. Thus, when the elderly person could no longer be properly cared for in a special care home, he or she could be transferred to the home for the aged itself.

Approved private homes under SHCP are now know as 'satellites'. They served approximately 180 elderly persons in 12 municipalities in the 1950s and early 1960s. The expenditure on SHCPs was rather small, rarely exceeding $25,000 a year during the first 10 years of the SHCPs operation. By 1980, 600 individuals were in satellite homes.

Shelter

Overview

The housing policies of the Federal and Provincial Governments cannot be easily separated in view of the intermingling of activities through shared jurisdiction and cost-sharing. Nor can housing policies in general be easily separated from those which bear directly on the elderly.

Ontario housing policy in the post-war period can be divided into three eras: 1945 to 1964, 1965 to 1975, and 1976 to the present. Between 1945 and 1964, housing policy was oriented toward easing the housing shortage experienced throughout Canada as a result of the Depression and World War II. The second era, 1965 to 1975, was characterized, initially, by a focus upon the rental housing needs of low-income households and, subsequently, by a focus upon the rental and homeownership needs of moderate and middle-income households.

With regard to housing for the elderly in particular, *The Elderly Persons Housing Aid Act* of 1952 provided the impetus for the construction of low-rental apartments for senior citizens. Although the fiscal constraint of the last two years, since early 1979, has affected construction of elderly housing units, the period 1975-80 taken as a whole witnessed rapid growth in provincial expenditure and the availability of housing units for the elderly. During this five-year period, expenditures rose from $15.8 million in 1975 to $77.6 million. The number of senior citizens housing units under management in Ontario grew from 24,220 to 62,367 over the same period.

History

1945-1964

Housing policy until 1964 was largely dominated by a desire to increase residential construction. The Depression and World War II had left Canada with a housing shortage. The two major programs of this era were the federal residual lending program and the federal loan insurance program.

The National Housing Act of 1944 permitted the Federal Government, through the Central Mortgage and Housing Corporation (CMHC), to make joint loans with private lending institutions and provide a guarantee to eliminate private lenders' risk. In 1954, this was replaced by a loan insurance system whereby borrowers paid an insurance premium to CMHC on loans advanced by private institutions.

The direct lending program of CMHC ('residual lending') was established to permit the use of public funds for mortgages to finance new residential construction when private sector funds were unavailable. The program was scarcely used until the 1950s, but thereafter, it dispensed vast amounts of money to finance mainly single detached housing.

Each of these programs was developed in response to the need for a greater supply of housing. Two other moderately-sized programs also existed in this era and had a parallel intent. CMHC established a system of Home Improvement Loan Insurance in 1955 and, after 1961, a package of loans and grants to municipalites for sewage facilities.

The philosophy of the day was to assist the private sector. CMHC was a benevolent banker, ensuring houses were built. There was some concern with the problems of low-income households, but it was assumed that the most appropriate government response was to rely on 'filtering': when new units were built for middle-income households, old residences would filter down and be occupied by those with lower incomes.

The programs offering direct assistance to low-income families—federal-provinicial (public) housing and entrepreneurial (limited-dividend) housing—remained relatively modest throughout the period. Under the federal-provincial program the two levels of government were partners in building and operating housing which would be rented to selected low-income households. Rents were established according to ability-to-pay rather than to amortize the costs of the project, so that operating subsidies were required. The Federal Government contributed 75 percent of the operating subsidy and the capital cost, while the province contributed 25 percent and could pass on a share of this to the involved municipality. In most instances local initiative and support were required to establish a federal-provincial housing project. The limited-dividend program made loans available to private entrepreneurs to build housing which would rent at below-market rates. Rentals could only be changed with the approval of CMHC and were set to guarantee a fixed, limited return to the owner. These rental units were intended for low- and moderate-income households. The operators of the dwellings were required to check tenants' incomes annually, and an income ceiling for eligible tenants was established by CMHC.

The Elderly Persons Housing Aid Act, 1952.

The exception to the dearth of activity on the part of the junior levels of government, as far as the elderly are concerned, was *The Elderly Persons Housing Aid Act* of 1952. The construction of apartments for Ontario's senior citizens derived its impetus from the passage of this act. The act sought to encourage municipalities to construct low-rental housing for the elderly under the *National Housing Act* by making provincial grants to limited dividend housing corporations of up to $500 per unit or 50 percent of capital costs, whichever was less.

Between 1952 and 1966, provincial grants under *The Elderly Persons Housing Aid Act* came to $2,700,900. By the end of 1966, 3,535 low-rental apartments for the elderly had been completed.

1965-1975

Activities through 1964 were dominated by a concern to improve the operation of the private market. In the early 1960s, the approach of government began to change although the insurance program remained

and extensive residual lending continued until 1972. Attention shifted from a concern with insufficient supply to a perception of the housing problem as one of insufficient income.

The amendments to the *National Housing Act* in 1964 marked the beginning of the new phase. The greatest change was the emphasis given to public housing. The 1964 amendments offered an alternative to the partnership cost-sharing arrangements: the Federal Government would provide 90 percent of the capital cost and share 50 percent of the operating subsidies for provincially or locally owned and operated public housing. In large part to facilitate use of these arrangements, the Ontario Housing Corporation (OHC) was established in 1964.

The program represented a massive commitment of resources and a fundamental change in housing policy. Housing became classed with education and health care as something to which everyone was entitled as a right.

With regard to OHC it is important to note that the low-rental housing units constructed under *The Elderly Persons Housing Aid Act* were transferred to and consequently managed by OHC. In 1976-77, provincial grants under this act came to $318,500.

The other program for low-income households, entrepreneurial or limited-dividend housing, was utilized somewhat differently during this time. In the mid-sixties it was almost unused because of a growing belief that private entrepreneurs were not suitable as operators of social housing. From 1969 to 1973 the program was extensively used again, although its aim was more to increase the stock of rental housing. Rents were still controlled to limit the rate of return, but the hope was to provide accommodation which rented at $20 below market rates, so that moderate-income rather than lower-income households became the main tenants.

It was hoped that a replacement for private entrepreneurs as operators of social housing for lower-income households outside public housing would be non-profit groups. In 1964 amendments provided a special subsection dealing with non-profit housing which had previously used the limited-dividend provisions. The assistance was in the form of loans on generous terms but with no subsidy for operating losses. Non-profit groups used the program to build housing for the elderly and hostels for single men and women. Growth has been slow but steady. In 1973, non-profit co-operative housing assistance became available.

In the late sixties and into the mid-seventies, public housing became the subject of intense and continued criticism. Its high-rise complexes were called ghettos for the poor. The sites were often far from services, employment, and recreation areas. The concentration of persons meant the households could not escape the stigma placed on those who received direct subsidies. A number of alternative programs were developed based on a rent supplement approach—for example, the rent supplement program, the community integrated housing program and the accelerated family rental housing program were started in Ontario but they have remained small. In these programs the subsidized units are no longer concentrated but spread out—no more than 25 percent of the units in a building may be used—often in privately owned and operated buildings. The criticisms and the troubles which often accompanied public housing in a neighbourhood meant increased municipal reluctance to initiate public housing projects. By 1976, although public housing was still being built, it was almost all for the elderly. In Ontario in 1973, 65 percent of the units had been for families, while in 1976 the proportion fell to only 7 percent.

During the second era of housing policy, attention at first concentrated on the problems of low-income households. However, it then shifted to include those of middle-income renters and potential home-buyers. Since the shift occurred even though the problems of low-income households had not been fully resolved, the approach deflected attention from low-income households by diffusing housing monies. Not only did programs which sought to redress market failure continue, but other programs intended to provide assistance to moderate and middle-income households were also developed. In 1967, Ontario introduced Home Ownership Made Easy (HOME) to offer ownership assistance while in 1973 the Federal Government introduced the Assisted Home Ownership Program (AHOP).

Since 1975

Since 1975, rental programs have continued their past trend of mixing tenants of different income levels in apartment blocks. Rental assistance to moderate income households also continues. With regard to home ownership assistance, almost none is now available.

The current era is characterized by restraint in public spending. Indeed, on January 1, 1979, responsibility for housing for the elderly was directed away from the federal-provincial programs requiring large public capital contributions and toward initiatives at the local level sponsored by non-profit housing companies and cooperative associations. CMHC and the then Ministry of Housing instructed local-level sponsors that capital funds must be borrowed from private lending institutions.

Housing Available for Ontario's Elderly

In 1980, there were just over 62,000 housing units under management for senior citizens (persons 60 years of age and over) in Ontario—almost six times the number under management a decade earlier. The majority are public housing units (three-fourths), one-fifth are operated by the Metro Toronto Housing Corporation Limited (MTHCL) and the remainder are rental supplement units. Since 1975, the numbers of both public housing and rental supplement units have doubled.

The provincial share of housing programs for senior citizens was $77.4 million in 1980—more than three times the expenditure by the Province a mere five years earlier ($23.2 million in 1975). Half of the 1980 expenditure was allocated for rent-geared-to-income housing, more than one-third was allocated to MTHCL, and just under one-tenth went toward rental supplementation. Privately assisted and community-sponsored housing for the elderly received the balance.

Since 1975, the rent-geared-to-income expenditure has quadrupled (from $10.3 million to $39.9 million). Allocations for community-sponsored housing, virtually nil in 1975, reached $2 million in 1980 as a result of the placing of housing responsibility for the elderly on non-profit and cooperative housing in early 1979.

Income Maintenance for the Aged

Overview

During the 1950s and early 1960s developments in income maintenance arrangements for the elderly were largely in response to federal initiatives. More recent developments were provincially-initiated within the context of innovative federal programs and new federal-provincial funding provisions. In contrast to its parochial income maintenance role 30 years ago, the Province of Ontario (together with the Federal Government) now shoulders major responsibility for the income security of the elderly.

In 1950, the Province spent, at the very most, about $40 million on 85,000 old age pensioners. This sum was cost-shared by the Federal Government. The growth in the number of income maintenance arrangements since that time has resulted in much broader coverage, greatly improved adequacy and enormous costs.

The maximum Old Age Pension was $40 in 1950. In 1965, the Old Age Assistance benefit stood at $75. Under the Guaranteed Annual Income Supplement (GAINS-A) program, single recipients were guaranteed $454 monthly at the end of 1980. Thus, the Province now guarantees an income that exceeds by a factor of 11 the provincial pension entitlement of 30 years ago while prices during the same period have increased by a factor of 3.5.

The number of current GAINS-A recipients (more than 240,000) is three times the number of old age pensioners in 1950 (85,000). Current expenditure on GAINS-A ($90 million in 1979) greatly exceeds that for old age pensioners in 1950. In addition, Ontario's elderly received an estimated $254 million in tax grants in 1980. A small number of elderly persons receive family benefits and supplementary assistance.

History

Major Programs

The years immediately following World War II found the Province of Ontario assuming a small role in the income maintenance area. Government was only expected to provide minimal support for certain categories of people, including the aged poor. Indeed, the government role in social policy in general was seen at the time primarily as that of regulator.

In 1929, Ontario enacted *The Old Age Pensions Act.* The act provided for a means-tested old age pension for individuals 70 years of age or over whose income, in 1950, did not exceed $600 per year. In 1950 and 1951, there were 85,100 and 95,100 old age pensioners respectively. The maximum pension was $40 per month.

Federal initiatives led to a major change in the income maintenance system for the elderly. Beginning in 1952, the Federal Government replaced its previous shared-cost contribution to provincial means-tested old-age pensions with a purely federal universal old age pension, Old Age Security (OAS) for all citizens 70 years of age and over. OAS reflected a fundamental change in philosophical stance in the acknowledgement of pension entitlement as a right without an income test in certain categories.

With the introduction of OAS and discontinuance of *The Ontario Old Age Pensions Act,* much of the cost of incomes for the aged was removed from the provincial budget. Ontario, however, introduced *The Old Age Assistance Act,* a joint federal-provincial program to meet the needs of individuals 65-69 years of age, in the same year. The maximum permissible income under Old Age Assistance (OAA)

was $720 per year for an individual and $1,200 for a couple. The maximum OAA benefit was $40. With the passage of *The Old Age Assistance Act* the Province recognized the aged population includes 65-69 year olds and that this segment of the population has financial need.

The provincial share of OAA cost increased substantially over time—from $4.6 million in 1953 to $10.5 million in 1965. As OAA benefit levels increased (to $55 in 1958, $65 in 1962 and $75 in 1964), residency requirements were liberalized (from 20 years to 10 years in 1958), and the size of the elderly population of Ontario grew. Between 1953 and 1965 the number of OAA recipients increased by 25 percent—from 20,000 to 25,000. Up to 1965, OAA was received by approximately 13 percent of Ontario's 65-69 year-olds annually.

The year 1966 witnessed a decline in the number of OAA recipients. This was largely attributable to the Federal Government's decision to lower the OAS eligibility age to 65 one year at a time beginning in 1966.

The Canada Pension Plan (CPP) was also introduced in 1966. CPP added a contributory layer on top of the non-contributory old age security system. Senior Ontario welfare authorities were among those who had promoted such a contributory plan. They felt it was preferable to continued enlargement of the tax supported transfers involved in the existing combination of the Canadian universal flat-rate old-age pension (OAS) with needs-tested provincial (and municipal) supplementation.

A third Federal Government initiative in 1966 was the introduction of the Guaranteed Income Supplement (GIS) whose purpose was to provide a needs-tested benefit to those whose income under OAS, or OAS plus CPP, was below an established minimum.

In July, 1974, Ontario introduced GAINS—the Guaranteed Annual Income Supplement—for low-income pensioners. The GAINS program provides a monthly payment to augment OAS and GIS benefits to guarantee a minimum level of income. By the end of 1980, single pensioners in Ontario were guaranteed an annual income of $5,320 and pensioner couples an annual income of $9,979. In 1979, some 240,000 pensioners were beneficiaries under the GAINS program, at a cost to the Province of $90 million.

The Ontario tax credit program was introduced in 1972 with the refundable property tax credit. The property tax credit was designed to alleviate this tax burden for persons with low and moderate incomes. In 1973, the sales tax credit and the pensioner tax credit were introduced to provide additional relief, up to $500, on the basis of age, family circumstances and taxable income. In 1979, 710,000 Ontario senior citizens received credit benefits at a cost to the Province of more than $200 million.

In 1980, the tax credit system was replaced by a property tax grant of up to $500 and a $50 sales tax grant. The 1980 Ontario Budget estimated that the property tax grant would deliver $214 million in direct benefits. The value of sales tax grants for the elderly was expected to reach $41 million in 1980.

Other Programs

At the same time as income maintenance was developing at the provincial and federal levels, the municipalities assumed responsibility for an income-tested program of supplementary assistance for people, including the aged, who may need help with, for example, high shelter or drug costs. These payments were introduced in 1958 under *The General Welfare Assistance Act* and provide up to $20 per month per person. This act replaced the long-standing *Unemployment Relief Act* (1935).

Despite the gradual lowering of the OAS eligibility beginning in 1966, a substantial number of Ontario's elderly remained ineligible for OAS due to the program's residency requirements. The OAA program was incorporated under the umbrella *Family Benefits Act* legislation in 1966. The legislation provided monthly allowances and other benefits to persons in need of long-term financial help. Such persons include the blind, disabled, permanently unemployable, mothers with dependent children, people caring for foster children and the aged. In March, 1970, more than 9,000 elderly persons were in receipt of family benefits. By 1980, however, only about 3,500 persons over 65 were receiving Family Benefits. During the course of the 1970s, Canadians over 65 who met the residency requirements became eligible for the CPP pension in ever-growing numbers.

Appendix B

Review of Recommendations to Government

As one of its first priorities, the Task Force reviewed recent reports and recommendations of advisory and special purpose interest groups relative to policies for the aged. Reports and briefs from the following organizations were reviewed in detail:

General Interest Groups

- The Ontario Advisory Council on Senior Citizens
- United Senior Citizens of Ontario (USCO)
- Provincial Council of Women
- Catholic Women's League
- Ontario Federation of Labour
- Northwestern Ontario Chamber of Commerce

Planning Agencies

- Ontario Council of Health
- Ontario Welfare Council
- District Health Councils

Service Providers

- Campaign for Community-based Services
- Ontario Association of Homes for the Aged
- Ontario Homemaker Agencies

Appendix C

Statistical Profile of the Elderly

A Demographic Information

1 Population Projection, 1976-2021
2 Marital Status, 1976
3 Living Arrangements, 1976

B Income Situation

1 Composition of Income, 1975 and 1978
2 Levels of Income, 1971-1977

C Health Status

1 Functional Ability
2 Health Characteristics
3 Morbidity
4 Mortality
5 Life Expectancy

This statistical review was prepared with the assistance of staff of the Ministries of Health and Treasury and Economics.

Table A-1

Population of Ontario, 65 years of age and over, by sex, 1976 and projected to 2021

(in thousands)

	1976			1981		
	Male	Female	Total	Male	Female	Total
65-74	207.0	251.2	458.2	239.7	289.9	529.6
75-84	84.0	136.0	220.0	100.6	161.3	261.9
85+	19.4	41.4	60.8	22.1	51.7	73.8
Total	310.4	428.6	739.0	362.4	502.9	865.3
Ontario	4,096.9	4,167.6	8,264.5	4,320.5	4,410.4	8,730.9
	1986			1991		
65-74	264.7	324.8	589.5	303.9	379.5	683.4
75-84	118.0	188.2	306.2	137.6	218.1	355.7
85+	26.5	64.5	91.0	31.9	77.9	109.8
Total	409.2	577.5	986.7	473.4	675.5	1,148.9
Ontario	4,532.6	4,642.0	9,174.6	4,715.2	4,845.6	9,560.8
	1996			2001		
65-74	335.3	410.6	745.9	340.0	406.4	746.4
75-84	152.3	245.5	397.8	176.9	289.7	466.6
85+	38.0	93.2	131.2	44.8	110.0	154.8
Total	525.6	749.3	1,274.9	561.7	806.1	1,367.8
Ontario	4,854.5	5,007.4	9,862.0	4,954.2	5,131.3	10,085.5
	2021					
65-74	917.3	1,075.0	1,992.3			
75-84	229.3	367.9	597.2			
85+	82.1	148.6	230.7			
Total	1,228.7	1,591.5	2,820.2			
Ontario	5,071.6	5,377.0	10,448.6			

Assumptions: net external migration–30,000
fertility level–low
Ministry of Treasury and Economics

Table A-2

Marital status by age group and sex, 1976

	Male		Female		Total	
	#	%	#	%	#	%
65-74						
*Unattached	43,575	21	130,330	52	173,905	38
Married	163,200	79	120,800	48	284,000	62
75-84						
*Unattached	29,410	35	103,640	76	133,050	60
Married	54,505	65	32,580	24	87,085	40
85+						
*Unattached	11,710	60	38,175	92.5	49,885	82
Married	7,725	40	3,050	7.5	10,775	18
Total 65+						
*Unattached	84,695	27	272,145	64	356,840	48
Married	225,430	73	156,430	36	381,860	52

*UNATTACHED simply means "not married". This category includes those elderly who are single, widowed, divorced, or separated.

Source: Statistics Canada. *1976 Census of Canada, Vol. 2 Population: Demographic Characteristics* (Marital Status by Age Groups, Table 22).

Table A-3

Social Profile
Living arrangements for 65+ by sex, 1976

	Male		Female		Total	
	#	%	#	%	#	%
1 Economic Family	220,725	71	170,015	40	390,740	53
2 Other Family Arrangements	31,050	10	79,785	18.5	110,835	15
3 Living Alone	36,485	12	135,455	31.5	171,940	23
4 Collective Housing	22,140	7	43,345	10	65,485	9

Notes:

1 The family in this case is a economic family which is defined as a group of two or more persons living together and related to each other by *blood, adoption,* or *marriage.*

2 Includes persons living with economic families of which they are not a member and persons sharing households with other non-family persons.

3 Does not include persons living alone in collective housing.

4 Includes persons living in hotels, motels, nursing homes, staff residences, military and work camps, jails and penitentiaries, rooming and lodging houses and other institutions.

Source: Statistics Canada. *1976 Census of Canada, Vol. 2 Population: Demographic Characteristics* (Household and Family Status By Age Groups–Table 47).

Table B-1 Income Situation

Composition of income–source of income of pensioners–based on income tax data

INCOME SOURCE	1975 Number of Pensioners (thousands)	1975 Percentage of Total Pensioners	1978 Number of Pensioners (thousands)	1978 Percentage of Total Pensioners
Employment	88	14.2	91	12.3
UIC Benefits	26	4.2	20	2.7
OAS Benefits	609	97.9	719	96.9
Private Pension	218	35.2	270	36.4
CPP Benefits	241	38.8	380	51.2
Investment	455	73.2	560	75.5
Capital Gains	27	4.3	74	10.0
Actual Number of Pensioners	622	100.0	742	100.0

Source: Ontario Ministry of Treasury and Economics, from Income Tax Data (sample of approximately two percent) prepared by Revenue Canada.

Footnote:

Definitions:

- –the term pensioner refers to all taxfilers age 65 or over, regardless of source or level of income;
- –private pension refers to company, civil service, military pensions, etc. RRSPs do not make a significant contribution at this time; their importance will increase over time;
- –investment income is mainly comprised of interest and dividends;
- –capital gains result primarily from sales of stocks and bonds, art, precious metals, a second residence, cottage, and personal collections, e.g. stamps, jewellery, antique cars.

Notes:

- –the following types of income are not reported for tax purposes: *GIS, GAINS,* Workmen's Compensation payments, War Veterans pensions, welfare payments such as FBA and GWA, spouse's allowance, blind person's allowance, etc. *GIS and GAINS make a significant contribution to the income of many elderly persons.* Income tax data, therefore, to some extent at least may understate income levels at the lower end of the scale;
- –the number of pensioners reporting income from OAS varies between 95.5 and 98.0 percent of all pensioners. (Residency requirements make most of the remainder ineligible to receive OAS. There may also be sampling variations.) The distribution of income class, therefore, is almost identical with the distribution of all pensioners;
- –the source of income reported by the next largest number of pensioners (73.0–75.5 percent) is *investment income.* In many cases the dollar amount is small, representing interest from bank accounts and Canada Savings Bonds;
- –the accuracy of the distribution figures for source of income is open to some doubt, due partly to the size of sample–approximately two percent, OAS is most accurate, UIC probably the least, (less than 3 percent of pensioners reported income from UIC in 1978).

Table B-2 Levels of Income–Consumer Finance Survey

Median incomes, all individuals with income, Ontario by age and sex 1971, 1973, 1975 and 1977

	Current Dollars					Constant (1971) Dollars				
	1971	1973	1975	1977	% change 1971-1977	1971	1973	1975	1977	% change 1971-1977
Male	$	$	$	$		$	$	$	$	
65-69	4,495	5,483	6,990	6,695	48.9	4,495	4,865	5,047	4,164	–7.4
70+	2,265	2,771	3,774	3,997	76.5	2,265	2,459	2,725	2,486	9.8
Ontario	7,260	8,657	10,936	12,972	78.7	7,260	7,681	7,896	8,067	11.1
Female										
65-69	1,500	2,146	2,550	3,296	119.7	1,500	1,904	1,841	2,050	36.7
70+	1,672	2,062	2,671	3,343	99.9	1,672	1,830	1,929	2,079	24.3
Ontario	2,276	2,891	3,951	4,922	116.3	2,276	2,565	2,853	3,061	34.5
Combined Total:						**Combined Total**				
65-69	2,381	2,949	4,209	4,534	90.4	2,381	2,617	3,039	2,820	18.4
70+	1,828	2,332	2,982	3,575	95.6	1,828	2,069	2,153	2,223	21.6
Ontario	4,764	5,607	7,100	8,345	75.2	4,764	4,975	5,126	5,190	8.9

Source: Statistics Canada, Consumer Finance Survey

Table C-1 Health Status

Functional Ability: Summary

	Independent	Partially Dependent	Dependent
1 DHC Studies[1]	67%	27%	6%
2 Manitoba[2]	83%	19%	11%
3 USA Mobility[3]	82%	12%	6%
4 USA Mobility[4]	70%	21%	8%

1 Independent persons are able to look after their own home maintenance, shopping, personal care, meal preparation.

2 Partially dependent people have some difficulty with any one of home maintenance, heavy cleaning, light housekeeping and/or food shopping.

3 Dependent people have difficulty with any one of the above (item 2) plus meal preparation, bathing and dressing.

The studies are grouped under these categories merely to indicate the range in needs. In fact, each study has slightly different methods of assessing needs. However, a rough over-all picture can be found from these figures.

[1] Kershner, J. *A Comparison of Four Community Health Surveys.* Ministry of Health, 1980.

[2] Manitoba. *Population in need of Home Care.* Home Care Working Group Report, 1974.

[3] Home Health Services in the United States, *A Report to the Special Committee on Aging.* United States Senate, 1972.

[4] Brody, S. "Comprehensive Health Care for the Elderly", *The Gerontologist,* Winter, 1973, p412-418.

Table C-2

Health Status–Health Characteristics: Surveys

	Kenora/Rainy River June 1979 %	Renfrew County March 1979 %	Durham Region July 1979 %
Most Prevalent Health Problems			
Arthritis	57.5	46.4	48.7
High Blood Pressure	31.8	39.9	33.4
Hearing Impairment	30.1	28.4	25.3
Heart Trouble	21.9	22.3	25.7
Breathing Problems	21.9	21.9	21.4
Circulatory Problems	21.9	16.5	24.2
Bone Fractures	19.9	20.9	26.8
Anxiety and Depression	19.2	21.9	16.0
Digestive Disorders	17.5	21.6	20.0
Injuries	11.0	15.8	11.9
Falls (at least once in a year)			
Tasks Presenting Greatest Difficulties (figures in brackets 'not able to do')			
Heavy house-cleaning	18.3 (13.6)	18.6 (25.2)	10.6 (12.4)
General home maintenance	21.6 (14.6)	16.7 (25.4)	7.6 (13.3)
Walking up and down stairs	22.2 (2.4)	21.9 (3.7)	1.0 (1.1)
Moving around inside home	12.0 (0.3)	11.5 (0.7)	4.0 (0.5)
Light house-cleaning	10.1 (1.7)	10.8 (5.1)	2.9 (1.8)
Food shopping	6.2 (3.5)	6.6 (6.2)	2.6 (4.0)
Preparing a meal	4.2 (1.7)	4.7 (2.5)	2.9 (1.6)
Washing and bathing	4.1 (0.7)	5.0 (2.9)	5.5 (1.0)
Dressing and undressing	3.7 (0.7)	4.6 (1.1)	3.5 (0.6)
Dialing a telephone	2.1 (1.7)	2.2 (1.8)	– (2.6)

Source: Kenora and Rainy River DHC. *Survey of the Elderly: Health and Social Service Requirements in Kenora and Rainy River Districts,* Ontario Ministry of Treasury and Economics, June, 1978.

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Table C-3(i)

Health Status
Morbidity data–some major causes of hospitalization among elderly, Ontario (based on separation information data)

Diagnostic Category	Total Separations 65+ Years	Total Days Since Admission	Average Length of Stay (days)	Days of Care per 1000 Population (65+)
	Active and Rehabilitation Hospitals, 1978			
Diseases of the Circulatory System				
–Acute myocardial infarction	8,463	131,933	15.6	167.4
–Other ischemic heart disease	17,306	235,313	13.6	298.5
–Congestive heart failure, atrial fibrillation, heart block, specified and unspecified forms of heart disease	14,826	199,027	13.4	252.5
–Cerebrovascular disease–acute, ischemic, transient	11,540	266,938	23.1	338.6
–Diseases of arteries, arterioles and capillaries	3,724	84,030	22.6	106.6
Symptoms and Ill-defined Conditions	16,001	174,381	10.9	221.2
Diseases of the Respir. System				
–Pneumonia	7,573	114,474	15.1	145.2
–Chronic interstitial pneumonia, bronchiectasis & other lung diseases	4,484	65,365	14.6	82.9
Cataract	8,668	53,703	6.2	68.1
Hyperplasia of prostate	6,662	83,335	12.5	105.7
Fracture of femur	6,373	185,873	29.2	235.8
Total separations, 65+	267,914	4,042,040	15.1	5,127.1
	Chronic Hospitals, 1977			
Diseases of the Circulatory System				
–Ischemic heart disease	1,610	362,920	225.4	485.7
–Cerebrovascular disease	2,447	524,371	214.3	701.7
Fracture of femur	1,229	134,237	109.2	179.6
Total separations	12,965	2,235,774	172.4	2991.9

Table C-3(ii)

Health Status
Morbidity data–major causes of admission to extended care program, Ontario 1978 (all patients)

	Total Admissions	
Diseases of the circulatory system	15,635	
Mental disorders	10,160	
Diseases of the nervous system and sense organs	3,208	
Diseases of the musculoskeletal system and connective tissue	2,415	
Symptoms and ill-defined conditions	2,387	
Sub-total	33,805	85.8%
Total Admissions to Extended Care Program	39,395	100.0%

Table C-4

Health Status
Mortality Data, 1978

Rank leading cause of death (ICDA-8 Codes)	Sex	Total all ages	Age group 65-74	75-84	85+
1 Diseases of the heart (390-398, 402, 410-414, 420-429)	T	21,780	5,566	6,512	4,487
	M	12,339	3,580	3,203	1,516
	F	9,441	1,986	3,309	2,971
2 Cancer (104-209)	T	13,518	4,027	3,031	1,087
	M	7,395	2,383	1,672	477
	F	6,123	1,644	1,359	610
4 Cerebrovascular disease (430-438)	T	5,559	1,160	2,013	1,596
	M	2,495	649	866	543
	F	3,064	511	1,147	1,053
6 Pneumonia, Influenza, and Bronchitis (470-486, 490-493)	T	2,818	615	842	808
	M	1,663	435	492	382
	F	1,155	180	350	426
7 Diseases of the Arteries, Arterioles and Capillaries (440-448)	T	2,150	384	689	829
	M	1,102	288	336	292
	F	1,048	96	353	537
5 Accidents (E800-E949)	T	3,367	316	305	284
	M	2,279	191	138	109
	F	1,088	125	167	175
9 Cirrhosis of the liver (571)	T	1,009	226	61	9
	M	682	153	37	5
	F	327	73	24	4
8 Diabetes Mellitus (250)	T	1,042	302	325	167
	M	484	156	141	50
	F	558	146	184	117
3 All other causes	T	9,143	1,641	1,780	1,127
	M	5,350	1,000	971	478
	F	3,793	641	809	649
Total	T	60,386	14,237	15,558	10,394
	M	33,789	8,835	7,856	3,852
	F	26,597	5,402	7,702	6,542

Source: Ministry of Consumer and Commercial Relations, Office of the Registrar General

Note: Figures may be different from the published data due to revision.

Table C-5

Health Status
Ontario life expectancy, by sex and selected ages for selected years, 1956-1976

Age (years)	Sex	1956	1961	1966	1971	1976
60	M	16.08	16.17	16.23	16.57	17.01
	F	19.35	19.74	20.59	21.49	21.88
65	M	12.97	13.05	13.10	13.37	13.71
	F	15.56	15.90	16.72	17.57	17.92
70	M	10.23	10.27	10.36	10.59	10.82
	F	12.12	12.42	13.13	13.96	14.26
75	M	7.81	7.92	7.97	8.20	8.34
	F	9.12	9.31	9.93	10.74	10.95
80	M	5.81	5.97	5.99	6.17	6.24
	F	6.75	6.75	7.27	7.99	8.05
85	M	4.25	4.41	4.43	4.51	4.53
	F	4.98	4.77	5.20	5.78	5.69
90	M	3.07	3.21	3.24	3.22	3.19
	F	3.69	3.32	3.65	4.09	3.90
95	M	2.21	2.31	2.35	2.24	2.21
	F	2.75	2.29	2.54	2.85	2.62
At birth	M	67.80	68.32	68.71	69.55	70.55
	F	73.57	74.40	75.53	76.76	77.66

Source: Statistics Canada, "Provincial and Regional Life Tables" (1955-57, 1960-62); "Life Tables, Canada and Provinces" (1965-67, 1970-72, 1975-77)

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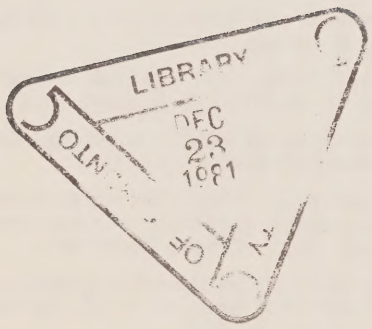

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